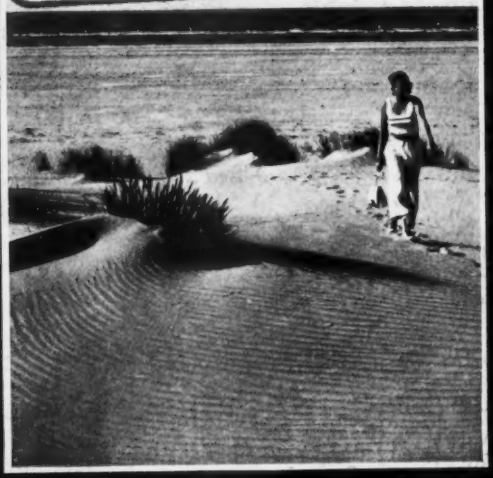
MEDICAL ECONOMICS



AUGUST, 1937

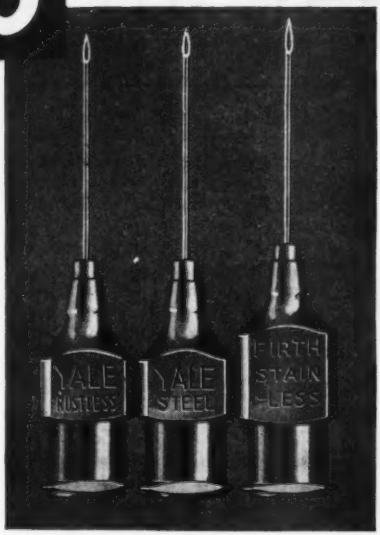
MEDICAL ECONOMICS

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

CONTENTS FOR AUGUST, 1937

H. Sheridan Baketel, A.M., M.D., *Editor* · William Alan Richardson, *Managing Editor* · J. T. Duryea Cornwell, Jr., *Associate Editor* · Russell H. Babb, *Advertising Manager* · Lansing Chapman, *Publisher*

3 B-D NEEDLES



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☆ SPEAKING FRANKLY ☆

CURRICULAR REFORM

TO THE EDITORS: I have read your editorial indictment of some of the medical schools of the country for their failure to give "adequate courses in medical economics" [see June issue, page 38].

There is, of course, room for a difference of opinion as to what constitutes an adequate course in medical economics... I gather that the writer of the editorial is of the opinion that the medical student should receive practical instruction in medical economics which would be of help to him personally. If I am correct in that interpretation, I beg leave to disagree with him on that point. I cannot but feel that it is beyond the province of the medical school to supply that kind of instruction to its students.

The kind of medical economics to bring before medical students is that which might be described as the relationship of the physician to society and the changes which that relationship has undergone throughout the period of recorded history.

A course given along such lines by competent instructors ought to be of great value to the medical student. However, it is not easy to find persons competent to give such courses. I imagine that there are few physicians in the country who have the requisite first-hand information, based upon individual study, to present the subject in a broad, unbiased, and authoritative fashion. I am reasonably sure that if there are many qualified persons in our medical schools anxious to offer elective courses on the relation of the doctor to society, they will be accorded ample opportunity to display their wares.

I do not think any good purpose would be served if medical schools attempted to offer such courses without the proper personnel. Indeed, much harm might ensue if they did. Nor do I think that such courses should form part of the required work. That can well be left to the choice of the individual student.

You will understand, of course, that I am setting forth my own personal views, not those of my colleagues.

Alan M. Chesney, M.D., Dean
Johns Hopkins School of Medicine
Baltimore, Md.

TO THE EDITORS: We are very much in sympathy with agitation to have more medical economics taught in medical schools.

Stanford University School of Medicine does not give a formal course in medical economics as such, but several hours are set aside in our public health courses in which medical economics is presented and discussed. We are doing this in a rather complete manner, but do not make a complete course out of it.

L. R. Chandler, M.D., Dean
Stanford School of Medicine
San Francisco, Calif.

SANGER, NOT STONE

TO THE EDITORS: Please correct a misstatement in your otherwise accurate and interesting article, "The Battle

Over Birth Control" [June issue].

On page 84 the article says, "...Dr. Stone opened her Birth Control Research Bureau." As a matter of fact, the Birth Control Clinical Research Bureau was opened by Mrs. Sanger. Later Dr. Hannah M. Stone took charge as medical director.

In the early days it was necessary to have the bureau operate almost as if it were the private office of the clinician in charge. This was because of fear of the law.

We wish to give Dr. Stone full credit for having courage to take over the work at a period when assuming such a position was not as easy as it is today. But, to have the records straight, it should be understood that the work was initiated by Mrs. Sanger who assumed full financial responsibility for carrying on.

Cecil A. Damon, Exec. Secretary
Birth Control Clinical Res. Bur.
New York City

EYES BUT THEY SEE NOT

TO THE EDITORS: I was interested in your editorial comment on optometrists who call themselves doctors [July issue, page 17].

Undoubtedly, there are many honest, well-meaning optometrists who do not pretend to be anything else. With these men I have no quarrel whatever. But it is most unfortunate when a patient suffers progressive failure of vision due to some condition which should have received the attention of an eye *physician*.

The public is entitled to know the difference between the eye physician and the optometrist. A campaign of education along this line would be extremely worthwhile.

Walter F. Hoffman, M.D.
Seattle, Wash.

TO THE EDITORS: I want to compliment you upon your splendid editorial on the difference between medical and non-medical eye men.

Almost every patient who presents himself to an ophthalmologist comes with a self-diagnosis of the need of glasses. It is imperative in such instances to be able to distinguish between refractive errors and eye diseases. Non-medical refractionists are not qualified to do so.

William A. Boyce, M.D.
Los Angeles, Calif.

CANADIAN DIE LOADED?

TO THE EDITORS: I read your June article on health insurance in British Columbia ["Canada Casts the Die," page 42]. I am Canadian and have some knowledge of the condition of affairs in Canada.

To characterize the Canadian Commonwealth Federation as a "communistic" organization is tantamount to labeling the Democratic party "red." The federation is simply a liberal party in the true sense of the word.

I find it hard to believe that 612 out of 625 physicians were opposed to the British Columbia health insurance plan. There must have been a joker in the questionnaire on the plan submitted to members of the College of Physicians and Surgeons of British Columbia.

The sentiment in Canada is distinctly favorable to social reform, including health insurance.

Archie Fine, M.D.
Cincinnati, Ohio

"ORGANIZE!"

TO THE EDITORS: An article in a recent issue of a large newspaper stated that the doctors of Seattle, Washington, have organized for the purpose of boycotting hospitals which do not meet certain of their demands. Permit me to express the hope that the M.D.'s of the United States will organize on a similar basis and refuse absolutely to take part in any scheme of socialized medicine.

Socialized medicine cannot be put over on the profession if, as an air-

tight organization, we refuse to render medical services on such a basis.

A strike by physicians sounds cold-blooded, I know. But the alternative may be worse.

L. E. Thompson, M.D.
Salida, Col.

"OF, BY, FOR THE STATE?"

TO THE EDITORS: Congratulations on your complete and interesting report, "Economics Keynoted at A. M. A. Convention" [July issue]. Your interpretation of the significant doctrines which electrified the atmosphere about Atlantic City for several days is most valuable.

Senator Lewis said [in his address to the house of delegates]: "We know nothing about the patient; we don't recognize his existence . . . we recognize only an instrument called a citizen who is essential to the welfare of the government."

Are we to capitulate finally to the pressure of a totalitarian state which looks upon the citizen as existing for "the welfare of the government?" Must we admit, then, that ours is a people of the state, for the state, and by the state?

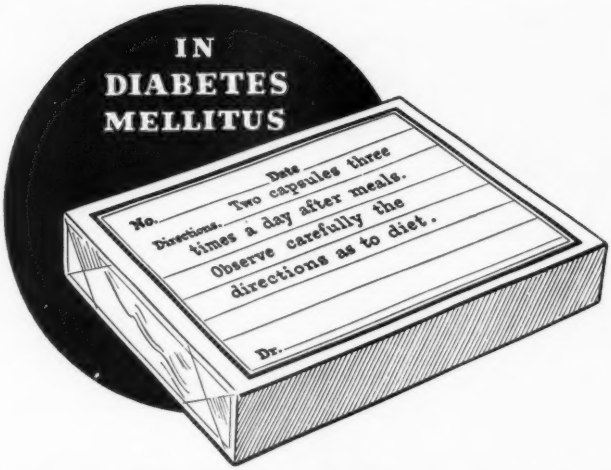
Who knows?

Mac F. Cahal, Exec. Secretary
Inter-Society Radiolog'l Comm.
Chicago, Ill.

CULT PROTECTION

TO THE EDITORS: Every prospective medical student should be thoroughly investigated as to his moral integrity, honesty, and probable willingness to adhere to the accepted modus operandi for arriving at a diagnosis. Certainly, efficient tests could be evolved for the purpose of determining a young man's tendencies in the matter of practicing medicine conscientiously.

Here's an example of what is happening in many localities: I was called to see a woman whose complaint was pain in the lower right quadrant. A young surgeon who had been called



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previously, upon being told where the pain was, had paced back and forth with his hands in his pockets and had said, "You have an acute appendicitis and will have to go to the hospital."

When the patient told him that she had not had an appendix for ten years, he countered with, "Then it must be your gall bladder!"

I learned that this woman had been seen by a succession of four physicians during a six-week period. Not one of them had made a vaginal examination. She had a pyosalpinx.

The young surgeon referred to had had intensive training; the others too, probably. So there was no excuse for their negligence.

Such instances cause the laity to despair of relief from medical men and to fly to the cults as a last resort. If every physician would give every patient a thorough, conscientious examination, using every means at the disposal of modern medicine, the cultists would find little to do.

G. M. Russell, M.D.
Billings, Mont.

LABORATORY WORK

TO THE EDITORS: Not enough office laboratory work is done by family physicians. Many older men either skip it entirely or refer their patients to technicians or to younger doctors for the simpler laboratory procedures.

Urinalyses and blood counts do not take long to do. Furthermore, they add to the doctor's prestige. Patients feel that he is a scientist as well as a clinician.

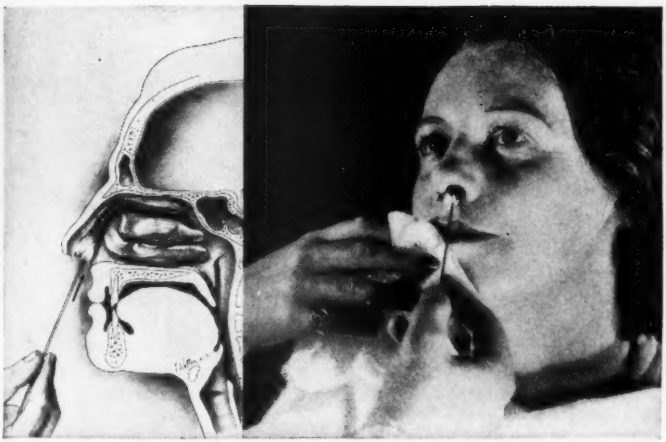
Many patients have come to me from older, more experienced men because word has reached them that I do laboratory studies on my patients. They feel that I am better equipped than the man who must refer even simple laboratory work.

No physician is too busy to do a urinalysis and complete blood count, including a stained smear study, on every new case coming to his office.

M.D., Syracuse, N. Y.

★Nasal Catarrh in the Middle Aged

ARGYROL



Nasal catarrh in the middle aged usually is caused by chronic suppurative sinusitis or chronic rhinitis of the atrophic or infectious types.

All of these conditions respond favorably to the Argyrol pack (Dowling). The tone of the mucous membrane and the erectile tissues is improved, drainage and ventilation of the sinuses is established, and quick relief is thus obtained. Surgical measures within the nose or involving the sinuses are frequently obviated by the use of the pack.

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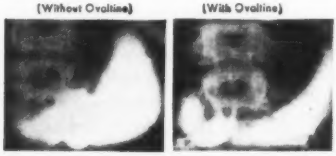
First—Ovaltine helps to restore normal appetite. It tempts the taste and in addition, it helps to stimulate the lagging appetite. It contains 57 International units per ounce of the appetite-restoring vitamin B. It also makes possible the prompt return of hunger by causing the stomach to empty starchy foods more rapidly. (See x-rays below.)

Second—Ovaltine possesses other special properties which are also important when digestion is under par. It not only aids the digestion of starchy foods, but it increases the digestibility of milk. Furthermore, Ovaltine itself is very easy to digest.

Third—Ovaltine adds important growth factors to the diet. It contains complete proteins, easily available carbohydrates, vitamins A, B_1, B_2 (G), and D, and the minerals calcium, phosphorus and iron.

Developed in Switzerland over 40 years ago as a food for convalescence, Ovaltine has stood the test of time. It makes an ideal food for underweight children because it combines both nourishing and protective food elements in an attractive form. Recommend the use of Ovaltine for underweight children and see for yourself the results it can bring.



The two x-ray reproductions show the stomach two hours after a starch meal was taken, with and without Ovaltine. The average decrease in gastric contents due to Ovaltine was 20%.

Let us send you a regular size can of Ovaltine for clinical trial with some undernourished child under your care. Address The Wander Company, 360 North Michigan Avenue, Chicago, Illinois, Dept. M.E. 8.

☆ SIDELIGHTS ☆

WHEN CITIZENS of British Columbia went to the polls a few weeks ago, compulsory health insurance was one of the issues at stake. Medical officialdom watched closely since the consensus was that "as British Columbia goes, so goes the Dominion."

The outcome of the plebiscite—110,508 votes *for* health insurance, 77,189 votes *against* it—would seem offhand to answer once and for all the question of how British Columbians feel about the matter. But does it?

The question voted on was hopelessly vague: "Are you in favor of a comprehensive scheme of health insurance progressively applied?" It did not even state whether it meant *compulsory* insurance or *voluntary* insurance. Little wonder, then, that more than 100,000 voters, through lack of understanding or interest, failed to answer the question at all.

One of two conclusions must inevitably be drawn: Either deplorable judgment was used in framing the question, or it was purposely so worded as to elicit an affirmative response.

SHOULD BUSINESS TRAINING be incorporated in the medical school curriculum?

It should not, contends Dr. Alan M. Chesney, dean of Johns Hopkins School of Medicine, in a letter to MEDICAL ECONOMICS (page 4, this issue).

Dean Chesney's opinion commands respect. It may even mirror that of other distinguished educators. But it is refuted, we feel, by two facts:

1. The number of medical schools which offer courses in economics is increasing steadily.

2. The desire among active physicians for information on business topics becomes daily more evident.

Twenty years ago, not one medical school in the country offered its students instruction in everyday business procedure. Today, such instruction is given in ten class A schools, and others plan to follow suit. Schools that have fallen into line have done so because of the insistent demand for business training and in spite of crowded schedules.

Proof of the interest of active practitioners in medical economics is likewise ample. Let anyone who doubts it talk with a few physicians at random and find out where their interests lie. Let him note also the unprecedented amount of space devoted to the subject in medical journals.

This publication alone receives thousands of letters a year from readers

who want advice or information. The volume of such correspondence has been growing steadily since the founding of the magazine in 1923.

Further evidence of the need for

medical-economic training would be superfluous. The facts cited—which can readily be checked—speak for themselves.

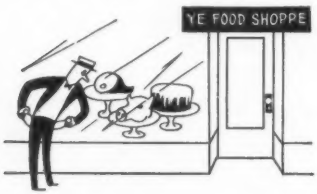
GULLIBILITY HAS INCREASED with prosperity. Better business bureaus, insurance companies, the police, and other authorities report increased activity on the part of blue-sky brokers, fake charity solicitors, and purveyors of worthless insurance.

Convictions obtained in recent months give striking evidence that swindle mills are working full time. For instance:

Before jail caught up with them, one group of operators had succeeded in selling $6,000,000 worth of stock in a fantasy called the Rayon Industries Corporation. Seven pious Brooklynites have been convicted for collecting donations to the "Gates of Mercy" and to the "Charity Church." They confused such eleemosynary projects with their own pockets.

There's no need to be an easy mark. Good banks and reputable stock, real estate, and insurance brokers are still to be found. But too often their proffered advice is ignored when surplus dollars are available.

In connection with charity rackets, read the warning issued by New York City's department of public welfare (page 94, this issue). If people will



only remember it, charity should batten while crooked solicitors starve.

THE ILL WIND of threatened state medicine, which has been blowing from Portland, Maine to Portland, Oregon, has actually wafted some good the way of the profession.

It has helped, for example, to strengthen medical organization. How? By encouraging physicians to take a more active part in medical society affairs and by swelling attendance at medical conventions (one association after another this year reports having broken its own previous attendance record).

The threat of socialization has been effective, too, in awakening the physician's sense of social responsibility. Conversely, it has stimulated the interest of the public in medical problems.

Thus, in these and other ways, the road has been paved for a better understanding in the future between doctor and doctored.

Who can deny the adage that blessings often come in disguise?

ASKED WHO the forgotten man is, the average intern would doubtless reply: "I am."

His bill of grievances is likely to include one or more of the following:

"I don't get enough clinical instruction."

"I'm not invited to staff meetings."

"No one takes an interest in my problems."

"There are entirely too few staff conferences."

In order to better its intern service from the standpoint of everyone concerned, the George F. Geisinger Memorial Hospital at Danville, Pa. is sponsoring several forward-looking moves.

To wit:

Staff members have formed a seminar which assures the interns an hour of didactic instruction each day.

The interns themselves organize and conduct weekly staff conferences.

Clinicopathologic instruction is given at intervals by the hospital pathologist.

Not only are interns invited to all

staff meetings, but the final staff meeting is given over exclusively to the intern and his problems.

Periodically, at meetings, each intern presents case history abstracts; and before completing his residency he prepares a thesis, suitable for publication.

Other hospitals take note!

IF THE COUNTRY'S 1,000 venereal disease clinics are to function with proper consideration for the rights of physicians, it is imperative that the medical men in each community where such a clinic exists insist upon the observance of three basic principles:

(1) That directors of venereal disease clinics shall be appointed by the state health department only after nomination by the county medical society and after approval by the state medical society.

(2) That a free first treatment may be given to any infectious patient, regardless of his ability to pay, but that thereafter free treatment shall be limited exclusively to the in'igent.

(3) That clinic physicians shall be paid for their services and paid adequately.

From an economic standpoint, the crux of the venereal clinic problem lies in proper investigation of cases.

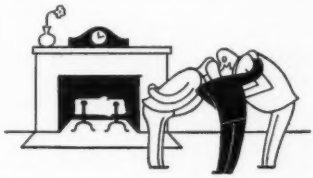
What evidence have we that able-to-pay patients will be weeded out? What assurance have we of the adequacy of investigations made by state social service workers?

In some clinics right now even those able to pay are not required to do so! In other clinics it appears to be the objective of social workers to herd in as many free patients as possible.

If your local medical society is playing no part in the control of these VD clinics, it is overlooking one of its basic obligations.

A PENNSYLVANIA PEDIATRIST writes us as follows:

"Physicians," he says, "have an unequalled reputation for talking shop during leisure hours. Any social gathering at which two or more happen to be present affords a golden opportunity



for them to go off into a huddle and unwind their ideas.

"Dr. A starts the discussion by announcing that just that morning he diagnosed an echinococcus cyst. Nor is the story complete until he has described its every detail and heaped himself with bouquets for his prowess as a diagnostician.

"Dr. B then recalls how he saw two cases of a similar nature during his internship. He tells how he surprised his hospital chief at the time by his brilliant diagnosis of them.

"Dr. C, a chronic skeptic, begins to doubt the diagnosis. He offers a few suggestions of his own.

"So the discussion waxes. Only after several hours have elapsed do the doctors remember that they are not at a medical meeting. Meanwhile, the reaction of the lay guests can easily be imagined.

"Sometimes even a fellow physician is anxious to forget medicine for a while. His chances are slim, however, if he runs into a chronic shop-talker. My vacation was almost blighted last month by one of these fellows whom I happened to meet at a seashore resort."

As our correspondent points out, enthusiasm for one's work is indeed praiseworthy. But social gatherings are no place at which to talk medicine. Interesting cases are more properly presented at hospital staff conferences, at county society meetings, or in small study groups.

S-T-R-E-T-C-H-I-N-G

His need for equipment was as great as his funds were small. But ingenuity solved the problem.

BY GORDON SIMMS

☆

WE WERE TALKING about the expense of equipping an office.

"I had no choice," said my host, an Atlantic City G.P. "I couldn't afford new furnishings, and I wouldn't use junk. So I had to work out an alternative. Here's the result."

His gesture took in the entire office. There was pride in his face as he contemplated it.

"To be specific," he said, "take a look at this desk."

I saw a glass-topped, executive-size mahogany desk—dignified, impressive.

"Believe it or not," he said, "this was once an old, battered, second-hand piece. It took a new lease on life when a mahogany finish was applied and a sheet of black vitralite glass was placed on top of it. The glass sheet cost only about $4 wholesale."

The lustre of the vitralite glass top showed to good advantage because the only objects on it were an ash tray, a calendar, a desk lamp, a fountain pen set, and a signal-light gadget.

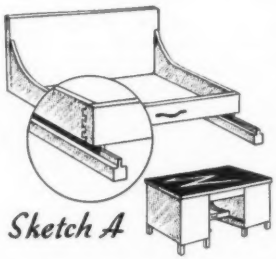
As I turned to the doctor he forestalled my question.

"I keep all the usual desk-top litter in this," he explained, reaching toward the back of the desk's kneehole and sliding forward a wooden tray (see Sketch A). In it were several letter files, a basket of active correspondence, a scrapbook for journal clippings, and several folders containing personal papers of one sort or another.

The tray measures 24″ wide and 17″ from front to back, leaving ample leg room when it is pushed all the way in. It glides on ball-bearing runners purchased from a local hardware store, and was built, stained, and installed, at a total cost of $2.

As we stood looking at the desk, my practical-minded companion observed: "It's not as satisfactory, of course, as a brand new one would be. But it's adequate until I can buy the suite I want."

We proceeded to an instrument cabinet over in a corner of the room



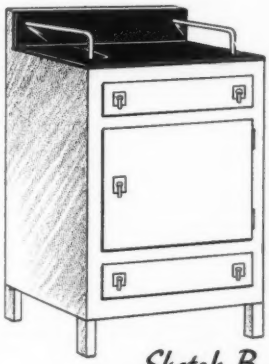
Sketch A

(see Sketch B). Its appearance gave no indication that it had been rescued from the discard. In fact, its mahogany finish was as lustrous

THE OFFICE DOLLAR

as its black glass top and backpiece and its chromium side bars and fixtures.

"As you can see," my host remarked, "regular plate glass was used on this cabinet. The undersurface is painted black. This gives about the same effect as vitralite glass but is less expensive. Of course, black-paint backing on a sheet of glass covering a *desk top* would not be as satisfactory as vitralite, since the paint would be noticeable under so large a surface. Here, however, it looks pretty good."



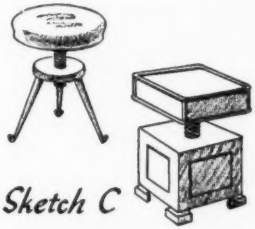
Sketch B

The cabinet's chromium bars had been made from towel racks purchased for 20c each. After one curved end had been amputated from each of the bars, they were attached to the top and backpiece of the cabinet. This was done by boring holes through the glass and through the wooden parts of the cabinet which the glass covers. Then the ends of the erstwhile towel racks (which had been threaded) were thrust through the holes and secured with nuts.

Homely drawer knobs and a handle on the locker door were replaced by chromium fixtures purchased from a hardware store.

The recreated cabinet holds instruments and supplies. On its top are placed bottles of medicines frequently used in the office. It cost $4.50—material and labor included.

Our next stop was at an examining stool, formerly a piano stool. As shown in Sketch C, the old trilegged base had been taken off and a square wooden base substituted. Like the desk and the cabinet, it had been given a mahogany finish. To carry out the design, the old round seat was replaced by a square one, cushioned and leather upholstered. The stool cost 75c originally, was rebuilt for $4.75.



Sketch C

"My x-ray room is across the

hall. Would you like to step over there with me?"

As I was about to accept the invitation, I spied a particularly interesting photograph on the wall. I recognized it as one that had been published in a recent issue of one of the better photograph magazines.

"I believe in changing my pictures every so often," the doctor said. "Patients get tired of seeing the same picture in the same old place time after a time. So do I, for that matter.

"Once a month my secretary rehangs the office pictures. In some the subject matter is changed also. I don't *buy* new pictures. I simply clip usable ones out of magazines. Miss Cook finds it easy to slip a new picture into a frame. When she's done, the job looks as finished as a bought picture."

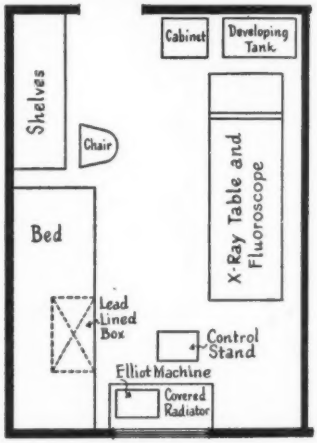
We went into the x-ray room. There, every square foot of space had been utilized efficiently, yet there was no feeling of crowding (see Sketch D). With careful planning plus a little ingenuity one room had been arranged to do the work of two. Result: a worthwhile saving on rent.

"The x-ray room serves not only for taking x-rays, but for developing them also," my host told me. "In addition, it functions as a treatment room.

"In that corner"—pointing—"you can see my developing tank about which all necessary materials are placed. Simple frame-type driers are used. There's neither space nor need for the larger type. Films are kept in a lead-lined box under the couch [made up like a bed] against the wall.

"When the room does duty for treatment purposes, there's no indication of its potential use as a darkroom. Those draperies over the black-painted window disguise it quite effectively, I think. Then, too, a few pictures placed judiciously join the draperies in lending an air to an otherwise purely workaday room."

An internal heat therapy machine rested on a strongly built and handsomely finished radiator cover. Distributed with an eye to conservation of space were a control stand,



Sketch D

a large cabinet (for filing journals, records, and supplies), a chair, and a smaller supply cabinet.

Back in the consultation room, I sat down in a swivel desk chair. Except for the fact that it was extremely comfortable, this chair has its prototype in thousands of offices. For $2.50 its hard wooden seat had been covered with a thick padding and upholstered. As the man who uses it pointed out, the net effect

is to make him *feel* better and to make the chair *look* better.

I saw how privacy can be achieved for a patient when one room has to serve for both consultation and treatment. This was done by the simple expedient of pulling out an extension arm holding a curtain. The arm is attached to the wall. Both it and the curtain it supports fold against the wall when not in use. Behind the curtain a nurse can prepare a patient in private for examination while the doctor works at his desk four feet away in the same room.

Radiator covers made of three-quarter inch wood beautifully stained do double duty in this office. They hide the unlovely outlines of the steam radiator and provide a surface for plants, vases, and rows of books.

Two of the chairs in the reception room were also called to my attention. Each had been reconditioned a few weeks previously. Although they had been bought at the same time, repairs on one had amounted to $3; on the other, to 25c. The discrepancy was due to the fact that one chair had been allowed to wait too long before being cleaned and repaired. The other had been reconditioned for less than a dollar at yearly intervals.

I learned that this Atlantic City doctor had long wanted Venetian blinds. They were too expensive several years ago. But he watched prices, saw them drop to a level he could afford, and then bought them.

"You'd be surprised how often something you want but can't afford falls within range of your pocketbook after it's been on the market for a while," he said. "It's not much trouble to check on prices from time to time."

"Speaking of prices," I said, "it strikes me that you paid unusually reasonable rates for what you had done here."

"My costs were reasonable," he admitted, "and I'll tell you why.

"First of all I made up a list of those whom my records showed to be skilled laborers. Among them there were carpenters, cabinet makers, glaziers, and upholsterers. Some owed me money, others were paid up.

"Then I got in touch with the delinquents on the list. They were more than willing to work in return for proportionate deductions from their bills. Jobs for which no delinquent could be found were offered on a regular pay basis to patients trained to handle them. It was agreed that I would pay for all materials used. Naturally, the people working for me were able to get materials wholesale. So I saved money there, too.

"All work was paid for at prevailing hourly rates—in bill-deductions for delinquents, in cash for the others. Any debtor who earned an amount in excess of his bill received the difference in cash.

"The arrangement was ideal for all concerned. The delinquents maintained their pride through working out their bills. My relationship with them as well as with those who were paid on a cash basis was cemented. I was charged reasonable rates and got material at wholesale prices."

"Your story will interest many of your colleagues, doctor," I prophesied.

"I hope so," he replied. "And, by the way, don't forget to point out

that what I've done here can be applied to almost any office-furnishing item. I just happened to need the particular things I've shown you. With a little ingenuity, there's no need to use makeshifts until you can afford new furniture.

"Another thing," he added as I prepared to leave, "no money was sunk into new but inferior stuff. So, I'm that much nearer to being able to buy the best."

"Right," I thought, "and you'll buy it soon if your initiative in building a practice equals your ingenuity in fitting out an office."

"A WORLD OF HEALTH"

ALMOST HALF A MILLION dollars is to be spent on the building (see cut) which will house an exhibit tentatively titled "A World of Health" at the New York World's Fair of 1939. The building will provide over 81,000 square feet of space. Of that area, the fair itself will contribute 10,000 square feet. The rest is to be financed by selected sponsors.

Summarizing the purpose of the exhibit, Grover Whalen, president of the fair, has explained: "We want to have the subject of medicine and public health brought to the consciousness of the average man. We want him to realize what is available to him in both knowledge and technique. . .This is not an exhibit for doctors, though they may be deeply interested in it and will participate in the planning."

Executives in charge of the proposed "World of Health" are Drs. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company; James R. Reuling, Jr.; George Baehr, of the New York Academy of Medicine; S. S. Goldwater, commissioner of hospitals for New York City; Victor Heiser, author of the recent best seller, "An American Doctor's Odyssey;" David J. Kaliski; and John L. Rice, New York City's commissioner of health.

"All in all," declares Dr. Dublin, "this building of the fair will present for the first time a unified, coordinated demonstration of the story of man in relation to medicine and health. The presentation will be definitely for the average man."

Some sixty sections will comprise the exhibit. They will embrace the outstanding health problems of mankind; they will detail the services available for prevention, amelioration, and cure; and they will forecast the brilliant future potential in a race fully served with these facilities.

LEARN ALONE AND LIKE IT

This isn't mere inspirational blather. Dr. Leppert suggests a practical method of postgraduate study which he has employed successfully in his own work and which he believes will be helpful to many another general practitioner.

BY CHARLES L. LEPPERT, M. D.

I'M A GENERAL PRACTITIONER. I like general practice. I do not want to specialize.

But . . .

I *do* want to broaden my scope. I'm anxious to augment my knowledge in a number of special fields. And I want to do it without spending too much time or money.

A big order—yes. But not one that can't be filled.

Several years ago when this problem first confronted me, I took stock to see what could be done about it. The most obvious solution, of course, was to take a series of postgraduate courses. But that raised several difficulties.

I could not abandon my practice for a month or six weeks every year. I had already searched in vain for the practical types of courses I wanted. And such courses as I could find included a number of related subjects in which I was well qualified and which I had no need to review.

While mulling over the situation somewhat hopelessly, it suddenly occurred to me that I could evolve for my own personal use a series of *made-to-order* postgraduate "courses." This would involve (1) the purchase of books and instruments relating to the particular specialty I wished to study, (2) careful reading of current literature on the subject, (3) special examination of patients in that particular field, and (4) short trips to clinics in order to observe at first hand the technique of leading specialists.

My first step was to select for study one of the several branches of medicine in which my knowledge was limited. I chose foot correction. Information on this subject would, I knew, be of practical use in my everyday work.

A good many of my patients had complained of foot trouble. This prevented their walking for exercise, as prescribed in my weight-reducing programs. I had been unable to help them. Nor did I know where or to whom to send them for relief.

In line with my new study program, I began a search for all available information on foot trouble. I studied the anatomy and physiology of the foot. I obtained help from a podiatrist I knew.

All patients who came to my office were questioned with regard

to possible disorders of the feet. If they had had any difficulty in that respect, I asked them to walk barefoot in order to find out why and how their feet were different from normal feet.

In time, I prepared an article on "Foot Correction" suitable for reading before my county medical society. Thus, I have come to develop a foot-correction side-line to my practice.

There is no doubt in my mind but that lasting benefit is derived from this method of study. It is obtained in a practical manner which is bound to make me a better doctor.

I do not have to finish my "course" at a given time. Thus, I can continue with the subject until I have definitely mastered it. I develop it and apply it as I go along.

You may listen to the best lectures, see the best work performed, and read the best books. But if this new knowledge is not put to practical use immediately, all that remains is the thought, "I had a course in that."

My present method of postgraduate study provides diversion—a hobby. I am never at a loss for something to do when practice is slack. My studies keep me feeling young and interested all year.

It is stimulating to learn more about my patients. At the same time, I am able to be of more service to them.

So far, I have completed the following work and applied what I have learned to my practice:

Surgery (both abdominal and thyroid). One day a week for six months at a nearby Chicago clinic.

Physiotherapy. One day a week at a Chicago clinic for three months.

Orthopedics. Leading textbooks and literature on foot correction; examination and treatment of dozens of patients in my own office.

Rectal diseases. Two brief visits to the Mayo Clinic; several visits yet to be made; acquired knowledge utilized for the benefit of my patients.

Sinus treatment. Watched technique of nose and throat specialists in Chicago and in nearby communities; observed work of Hazeltine at Johns Hopkins.

This year I am taking up proctology. I may still be working on the subject next year. At any rate, I shall continue with it until I have covered it to my satisfaction. Then I intend to purchase a cystoscope so that I can do my cystoscopies, pyelograms, and the like.

Before visiting a clinic for study, I usually write to obtain permission to attend. Now and then I go unannounced. In either case, I introduce myself, explain my interest in some particular field, and express the desire to improve my knowledge in that subject.

Also before visiting a clinic, I purchase two or three of the leading textbooks on the subject in which I am interested at the time. These are thoroughly digested. Later on at the clinic, on the basis of my reading, I am better able to understand and discuss what's going on. Thus, I get the best results from my observations in a limited time. The specialists at the clinic are invariably helpful and interested in what I am trying to do.

General reading of medical journals combines nicely, of course, with my textbook study. I cut out and file every worthwhile article and abstract on the special topic with which I am currently concerned.

My patients, too, show a welcome spirit of cooperation. They are often as interested as I am in their examination.

Each day, as a rule, around 5:00 P. M., I condense into written form what I have learned about the specialty I am studying. The material is then filed.

When changing the steps of a surgical technique, I write out the procedure and give a copy to the operating room supervisor. I explain it also, of course, to the man who assists me.

The following instance demon-

[TURN THE PAGE]

GRADUATE IN PATERNITY

FOR MORE THAN twenty years the Maternity Center Association, of New York City, has been dedicated to the instruction and care of pregnant women. Last year, however, the association yielded to paternal demands and instituted a course of instruction for expectant fathers.

To prove how thoroughly it converts prospective sires from tyros into adepts in baby care, the association recently permitted one of its star pupils to give a demonstration of the technique he had acquired. Mr. Paterbonus (he wouldn't give his right name) went through his paces in baby-bathing (see cut), baby-holding, bottle-sterilizing, and diaper-folding. A manikin was used instead of a real baby.

Miss Sara Ward Gould, assistant director of the association, rates Mr. Paterbonus' tenderness, skill, and general aptitude equal to that of the average prospective mother.

To his audience Mr. Paterbonus confided: "My hands used to tremble and my knees twitched when I began this course. But all my fear has banished now. I feel prepared to cope with any crisis."

The grand finale of the demonstration came when the paternity pupil performed that mystic rite known as bubbling the baby. "I pat it lightly until it burps," explained Mr. Paterbonus gravely, undaunted by the fact that his papier-maché darling failed to comply.

New York Herald Tribune

strates the practical value of my present study system:

Two years ago I was hitting veins in every abdominal incision I made. I knew I shouldn't have so much bleeding. So I spent one day each week for several weeks at a Chicago clinic. There I watched a master of surgery make his incisions. I still haven't grasped the technique completely, but I've improved and will probably continue to do so.

Along with my present system of self-education, I still find it advisable to attend medical meetings and conventions. True, not a great many practical ideas can be taken home and applied in everyday practice. However, some of the things learned do prove valuable as time goes on.

Furthermore, of course, conventions allow necessary diversion and relaxation. Meeting old classmates and exchanging ideas is a tonic which can't be had at home.

In coming years I expect my practice to be infinitely more interesting because of the system of self-education I've been following. I expect, for the same reason, to be of more help to my patients.

Naturally, independent study of this type has it limitations—especially when compared with the type of postgraduate work in which a man applies himself consistently to one branch of medicine with the idea of specializing in it. For the general practitioner, though, intent on improving his knowledge in special fields, I heartily endorse it. It keeps him out of a rut, enables him to compete successfully with other physicians, and helps him to hang on to that growing class of patients who feel that they must have specialized care.

I started my postgraduate plan while in country practice. Now I am practicing in the city. Yet in spite of the added opportunities for scientific study and research, I expect to continue along the same lines.

And why not? I have profited by it professionally, financially, and—if I may use the term—psychically as well.

PATIENTS' PROGRESS

FEW general practitioners today would deny the importance of adequate case histories. However, too many of us discontinue keeping records about a patient when we refer him to a specialist.

Whenever I make a referral, I ask the specialist for a brief *written* summary of his findings, diagnosis, and operative procedure. I follow this up with a request for a brief summary of the patient's progress midway during treatment and for a brief final summary at the time of the patient's discharge. Most specialists are glad to cooperate in this way.

As a result, my case histories are kept up-to-date. When a patient returns to me with new troubles, I am in a better position to diagnose and treat.

Incidentally, too, the patient can not help but be favorably impressed when he sees that the general practitioner has followed his progress through the duration of an ailment even though he was temporarily in the care of another man.—M.D., WASHINGTON, D.C.

A FUNERAL DIRECTOR SPEAKS HIS MIND ☆

BY PHILIP FERGUSON

Taking notes at medical school on death-bed technique is one thing. Practicing it is another. Here the director of a large Pittsburgh funeral service reminds physicians how to create good will by cooperating with the undertaker and by comforting survivors.

JOHN ANDERSON, bank clerk, waves goodbye to his wife and starts for work. Seven minutes later the weight of a truck parked on a hill proves too much for its improperly applied brakes. The heavy machine careens down the street, crushing Mr. Anderson against a store front. Before nightfall he is dead.

The funeral director, of course, takes prompt charge, helps to select a casket, attends to legal formalities, prepares the disfigured body for burial, and performs a hundred and one other tasks.

But he is not the only help. In time of death the physician, too, can render invaluable service. Families are quick to appreciate his aid; and it cements the bond between them and the doctor.

Where possible, the funeral should be arranged well in advance of death. It's like making a will; it smooths the way and avoids painful confusion after death.

Especially in chronic, incurable illnesses is advance preparation wise. If the physician will suggest to some member of the family who realizes the hopelessness of the situation that a funeral director be consulted, the handling of the case when the time comes can be greatly facilitated—to the relief of everyone concerned.

Twenty-five years ago funeral psychology was such that every effort was made to create an atmosphere of gloom and despair. Today the attitude is one of hope, of easing the sorrow just as much as possible. Here, again, the physician can render yeoman service. Any number of simple homilies

PHILIP FERGUSON

suggest themselves, such as "He put up a splendid fight, but the infection was too acute" or "It's best this way; she's been spared a lot of unnecessary suffering." Expressions like these, while admittedly banal, give real comfort to the family, especially when voiced by their physician whom they have learned to depend upon and trust.

One of the most helpful things the physican can do after death is to have the undertaker notified promptly. The sooner the body is embalmed, the better the cosmetic results. After *rigor mortis*, the task of successful embalming is infinitely more difficult.

The physician can assist in improving the final appearance of the body by closing the mouth of the deceased soon after death. It may be kept closed by tying a bandage around the chin and the top of the head.

False teeth should always be replaced. Their absence results in a sunken appearance which is difficult later to correct.

Raising the head on a pillow is a simple procedure but a helpful one because it prevents the blood from settling in the head. Similarly, it is well to cross the hands on the chest or at least to elevate them since venous congestion in a dependent portion makes embalming difficult.

The old custom of placing coins on the eyelids may once have helped ferry the corpse across the Styx. But today it simply causes discoloration.

One of the most common occupational diseases among morticians is streptococcic septicemia. It is contracted as a rule by an accidental needle puncture while embalming. If you want a clear conscience, always warn the undertaker when death resulted from puerperal sepsis, influenza, smallpox, or some like disease. Then he can take special precautions.

Always leave the death certificate with the body. This will save the family a great deal of needless bother and will also spare the funeral director the unwelcome task of having to pursue the physician until he gets the certificate. He must have it, of course, before embalming the body.

Incidentally, medical terms approved by the board of health should always be used on the certificate. If the body is to be shipped out of town, this is especially important.

The fact is sometimes overlooked that if no physician has been in attendance on a case during the 24 hours immediately preceding death, the coroner must be called. Also, if there has been any violence or if suspicious circumstances surround the death, permission must be obtained to move and embalm the body.

By understanding the process of embalming, you can better appreciate the complexity of the funeral director's task:

First the body is washed entirely with bichloride of mercury. Special attention is given to the hair, since in long illnesses it often goes without soap and water. The eyes too are bathed.

Embalming fluid (which consists principally of glycerin, formaldehyde, and coloring) is then injected into the axillary artery by gravity. At the same time the vascular system is drained from the axillary vein.

Into the pleural and peritoneal cavities a special fluid consisting of about 90% alcohol is injected. Cosmetics are next applied and the body dressed.

Now a word about autopsies.

Frankly, we don't like them because they quadruple our work and because the delay in obtaining the body makes what we do less effective. On the other hand, we realize the necessity for them and do everything in our power to help the progress of medical science.

All we ask is that the physician assist us by remembering the following points:

If a body has been autopsied, the embalmer must usually inject each carotid separately as well as both femorals or iliacs, instead of injecting only one axillary vein. The pathologist can help, therefore, by leaving long ends of these vessels and marking them appropriately.

It is unnecessary for physicians to sew up bodies thoroughly inasmuch as they must immediately be reopened. Simply use enough stitches to hold.

Extend the incision no higher than midway of the sternum. Always use the V- or Y-type incision on women.

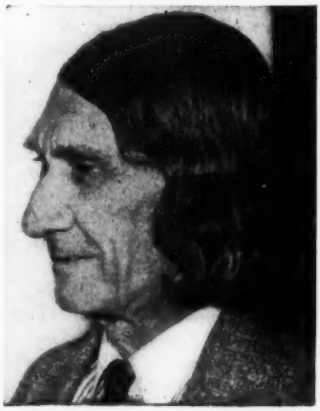
These courtesies which the funeral director asks of you are simple. Their observance will not interfere with your work on the body in any way.

For some time after death, of course, the illness and funeral of a member of a family constitute a favorite topic of conversation. The physician, among others, is certain to come in for his share of praise or censure.

If he has proved himself sympathetic and helpful, the bereaved are certain to publicize him as a fine fellow and a good physician. Thus, he can count on being summoned when illness strikes again in the future.

Even more satisfying is the thought that his aid and sympathy have brought solace to a family in its period of severest grief.

LONG HAIR, LONG LIFE



D. H. SIMMONS, M.D.

A THEORY of longevity plus respect for an old English custom are responsible for Dr. D. H. Simmons' partiality to long locks. A practitioner for twelve years in Fort Worth, Texas, Dr. Simmons explains that he has let his hair grow because experience as a physician and surgeon has convinced him that lengthy hirsute adornment is an aid to long life. Furthermore, being of English extraction, he has an abiding respect for British tradition which once demanded that men of medicine wear their hair long.

1,000

☆

The current campaign to stamp out venereal disease is as commendable as it is enlightened. To Surgeon General Thomas Parran, Jr. and his associates, for their initiative in leading the movement, the nation owes its lasting gratitude.

Medical men are in thorough accord with the objectives of the crusade. They realize only too well the need for more adequate means of case finding. They know, too, that everyone who requires treatment must get it.

On one score, however, serious objection is now being raised. This objection is directed against the wholesale establishment of venereal clinics in which free treatment is given to all, with little or no regard for their ability to pay.

Free service for the indigent is an accepted principle. Free service for the financially solvent is not. The venereal patient who can afford to pay belongs in the office of a private physician where he may obtain treatment at regular or reduced fees, according to his circumstances.

☆

SCARCELY LESS AMBITIOUS than James Aloysius Farley's post-office building campaign is the crusade of the U. S. Public Health Service to establish more and bigger venereal disease clinics.

At least 1,000 of these free clinics have been put into operation already. They may be found in every state of the Union, in the District of Columbia—even in U. S. possessions. And their number is growing steadily.

Two thousand more would be organized during the next five years if the Public Health Service had its way. Actually, about 500 are predicted—which will bring the total to 1,500.

Most new venereal clinics have their origin in the recommendation of a local health department, working in cooperation with the local medical profession. The department communicates with the state board of health, which, in turn, transmits the recommendation to the Public Health Service at Washington.

If the request is approved the Public Health Service authorizes an allotment out of its congressional appropriation. This fund is supposed to be matched, dollar for dollar, by the state.

Physicians to administer the clinic are selected from the local community. Most of them contribute their services free of charge, on a part-time basis, but the Public Health Service urges that they be paid.

"Once we have passed on a new clinic to be established on the recommendation of a local health board, and have appropriated funds for that purpose, the work and operations of the clinic are strictly in the hands of those within that

FREE VENEREAL CLINICS

local area," MEDICAL ECONOMICS was told last month by Assistant Surgeon General R. A. Vonderlehr, chief of the Public Health Service's Venereal Disease Division. In other words, when a clinic has been established, its policies are dictated thenceforth by the local health department.

The Public Health Service estimates that only about 30% of patients who come to the clinics return to receive full treatment. This is due to a number of reasons—mainly because, after several treatments, patients often believe they are cured and do not return.

From the standpoint of the medical profession, the methods used to determine the venereal patient's eligibility for free clinic service are vitally important. It may be said in this connection that there is, at least, *some* investigation of cases. Often a state social worker studies the patients' home life, working conditions, and financial status by

Acme

Heads together for venereal disease restriction—Surgeon General Thomas Parran, Jr. (right) and Assistant Surgeon General R. A. Vonderlehr, of the U. S. Public Health Service.

It is significant that more than 10,000 cases a month are cared for by these government-sponsored venereal agencies. Last year, Dr. Vonderlehr reports, 126,271 persons received treatment at the clinics. Of these, 79,905 were syphilis cases; the remainder, miscellaneous venereal.

Bachrach

CONGRESSMAN JOSEPH L. PFEIFER

Would raise annual appropriation for VD blockade from 8 to 25 millions.

"personal investigation." The routine questions are asked each individual in order to determine his eligibility.

On the other hand, in a number of instances there is no financial investigation whatever. The patient may be simply *asked* whether he can pay. Or he may be given a pauper's oath to sign. The District of Columbia Health Department has two clinics which are entirely free; even persons able to pay are not required to do so.

Dr. Vonderlehr estimates roughly that the average clinic is put into operation at a cost of between $3,000 and $5,000; but these figures are necessarily elastic, being governed by the location and size of the clinic, the scope of the work, and the needs of the particular community.

Most of the clinics employ about three doctors, plus several nurses. Last year, for primary treatment alone, probably more than 3,000,000 arsphenamine injections were given.

For the organization and operation of venereal disease clinics, each state is supposed to contribute as much money as that appropriated by the Public Health Service. Sometimes states fail to match funds in this way because they can not afford to do so.

The main factor holding back the venereal campaign at the present time is finances. This is expected to be remedied shortly with the passage in Congress of H. R. 3680, introduced by Representative Joseph L. Pfeifer, of New York, himself a physician.

Congressman Pfeifer's bill is, in effect, an amendment to that section of the Social Security Act which deals with social diseases. Under the present law, $8,000,000 is appropriated annually to the Public Health Service for its venereal campaign. The new bill authorizes an annual appropriation of $25,000,000.

H. R. 3680 was introduced in January. At the present writing the bill is still in the hands of the Ways and Means Committee, to whom it was referred upon its introduction.

Congressman Pfeifer has told MEDICAL ECONOMICS that he is pressing for early hearings on the measure and that he expects the bill to be brought up before the committee "in the near future." He is convinced that action will be taken on the bill at this session of Congress.

Between three and four thousand physicians are now rendering treatment in direct connection with the nationwide venereal disease cam-

paign. A great many of these men, as already pointed out, receive no compensation whatever, donating several hours a week of their time without charge.

In New York, physicians employed part time receive $10 for two hours' work. The relatively smaller number of full-time physicians receive in the vicinity of $3,000 a year. A few outstanding syphilologists, working for the Public Health Service, make well over $3,000 a year, but most of their income is turned back into the clinics. These men are paid for their support of cooperative research—not for their services.

The private physician usually charges, in round figures, from $150 to $500 for a full course of syphilis treatments. It costs the Public Health Service between $25 and $50. Regardless of this fact, Dr. Vonderlehr avers, the government venereal disease program "will cut very little into private medical practice."

Unwilling to agree with Dr. Vonderlehr are the members of such groups as New Jersey's Sussex County Medical Society. This association, for example, has declared itself definitely opposed to the establishment of a local free venereal clinic. "We expect to treat indigent venereal cases, and are only too willing to do it—just as we have always done," say Sussex County practitioners, in effect, "but we prefer to do the work in our own offices."

Declares Dr. Horatio M. Dorman, chairman of the venereal disease section of the Public Health Committee of the District (D.C.) Medical Society: "It would be most inadvisable to open the doors of the clinics indiscriminately to the general public for all sorts of free treatment. The place of those who can afford to pay is with the private physician." Moreover, Dr. Dorman has told MEDICAL ECONOMICS, "doctors who devote their time and effort to this activity should be paid on the same basis as any doctor engaged in the work."

The Public Health Service announces that new clinics will be established wherever state and local health departments are convinced that they are necessary. Adds one of its officers: "We have only begun."

CHARITY AT HOME

I USED TO WORRY a good deal about losing potential pay patients to clinics. But no more. I have originated my own "clinic," so to speak, with remarkably good results.

I now set aside one day a week for office appointments with patients who can not pay my regular fees. I do not tell them that I am holding hours specifically for the poor. I simply explain that my hours are less crowded on such and such a day.

As I find the finances of my various "clinic" patients improving it is easy for me to switch them back to the regular fee basis. I then have them come in again on non-"clinic" days.

Many of those whom I treat on my "clinic" day are able and glad to pay a little. A surprising number pay up eventually in full. Most important, however, is the fact that they remain *my* patients and do not go to an institution for treatment.—M.D., PENNSYLVANIA.

EDITORIAL

CERTIFICATION OF INDIGENTS

"IT SHOULD NOT *be the function of the out-patient department to pass upon the validity of indigents. . . The certification of indigents" should be undertaken "by central bureaus."*

So says Dr. Charles Gordon Heyd, A.M.A. ex-president, lending his support to a reform for which MEDICAL ECONOMICS *has long campaigned.*

Investigation of cases by out-patient departments is fundamentally inconsistent. Every hospital is anxious to make a spectacular showing for its board of directors. Nor is it any less eager to record a volume of service which will impress potential contributors.

How, then, can its social workers possibly do a conscientious job of barring those patients who seek admission undeservedly?

The human equation is ever present. If Mrs. White-collar is refused free treatment, no one gains. If, on the other hand, she receives medical care gratis—even though not entitled to it—everyone except the physician is pleased. The social worker inflates her ego by having done a good turn for some "poor unfortunate." The patient becomes a potential booster for the hospital. And the hospital itself chalks up another case with which to strengthen its appeal when the next money-raising campaign comes due.

This is no criticism of the country's hospitals and social workers. It is an indictment of the basically unsound system under which they so often operate.

Consider, by way of contrast, the advantages of a central registration and certification bureau. Such a bureau represents all the free and part-pay medical facilities within the community. It has the benefit of trained investigators, working in the public interest. It incurs no temptation to swell the ranks of those given free service. Efficiency in weeding out ineligibles becomes, in fact, a criterion of merit.

One of the cardinal evils which central registration tends to abolish is "shopping" for services. With no restraint placed upon them, dispensary patients often go from institution to institution, repeating expensive diagnostic tests. Under a central registry system, they are sent at once to the proper agency.

Though rare, central registries are by no means untried. Several communities have had such registries long enough to test them in the fire of everyday experience.

Enthusiasm for the central registry idea therefore has some basis in fact. As one endorser puts it: "Requiring indigents to be certified by a central bureau makes possible a substantial saving for the taxpayer. At the same time, it curbs exploitation of the generosity of physicians by those who are not in truth eligible for charity."

H. Sheridan Baketel

DOCTORS LEAD DOUBLE

A KANSAS SURGEON builds toys for his youngsters. A Milwaukee doctor has an amateur radio station. Chicago physicians collect birds' eggs, spoons, and snuff boxes. In Oakland, they carve furniture, collect Indian relics, make fishing flies, and study the medical life of Lincoln. In Minneapolis, one doctor dotes on his collection of feeding bottles. Equally zealous is another who collects old opera scores. Seattle physicians collect musical instruments in a big way—and play them! Cleveland reports jewelry making, the invention of surgical instru-

Eighty-one medical men entered 250 exhibits in this year's tenth annual show of the New York Physicians Art Club. Most popular attraction: the display of camera studies.

LIVES ☆ BY M. E. SCRIBNER

Nearly every physician has some pastime interest, whether it's collecting McGuffey Readers or hunting big game. Numerous hobby shows have been organized to display these interests. Here's what makes a hobby exhibit tick—and click.

ments, and novel translating. Members of the New York Physicians Art Club are partial to x-ray prints, hooked rugs, and candlesticks.

Who started the rage for doctors' hobby shows, no one knows. But the Physicians Art Club of New York held its tenth annual exhibit last April. Cleveland had its first show in 1929. Rochester, New York caught the bug in 1932.

Once started, the idea usually snowballs. Each year sees larger and more ambitious shows, plus a keener interest among participants and spectators. Successful exhibits held in New York, Cleveland, Milwaukee, Minneapolis, Oakland, Los Angeles, Detroit, Seattle, and other cities are conclusive evidence that physicians who prescribe hobbies for patients take their own medicine.

Arts and crafts top the list of hobbies in popularity. Every exhibit reports paintings, prints, sketches, photographs, and sculpturing. Wood carving, metal work, and archery are likewise popular. Collections of stamps, old firearms, and pottery appear frequently. Horticulture runs the gamut from peonies to orchids. Hobbies associated with medicine are scarce.

It doesn't matter much *what* your hobby is as long as you *have* one. If the fever hasn't already hit your neck of the woods, someone is bound sooner or later to propose, "Let's have a hobby show." When that moment arrives there will be no stopping the idea. So you'd better find out how it's done and be prepared.

Groups that have held successful shows cite several major problems in connection with them. Broadly speaking, they are—(1) proper direction; (2) stimulation of entries; (3) publicity; (4) transportation and setting up of displays; (5) deciding on the dates and place; (6) protection from breakage, fire, and theft; (7) deciding whether the exhibit should be public; and (8) handling visitors.

When a show is sponsored by a women's auxiliary, details are handled by the chairman of arrangements and her committee. County and local societies usually leave the details up to a member physician or to the executive secretary.

Once "hobby show!" is mentioned, little stimulation of entries is needed. Several groups have had to limit entries for lack of space. Cleveland never did finish cataloguing its second show because it was so swamped with applications.

IRON IN ITS MOST EFFICIENT SUBDIVISION

The absorption of iron into the blood depends upon many factors, not the least of which are patients' cooperation and comfort. Ovoferrin, iron broken down into its most minute subdivision, is not only highly efficient in its assimilability; it is tasteless, odorless, stainless, non-constipating and non-irritating to the teeth, mouth, stomach and intestines.

Yet Ovoferrin is "simple" iron—it does not contain complex compounds intended to mask or enhance the true effects of iron. It is held in its highly subdivided state by a protective protein colloid. With Ovoferrin physicians can combine a wide range of medication to meet special requirements. Supplied in 11-ounce bottles. Dose—one tablespoonful at meals and bedtime with water or milk. Write on professional stationery for full size gratis sample.

A. C. BARNES COMPANY, INC.
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Highlights of the Los Angeles hobby show were a display of firearms, a group of paintings, collections of shells, musical compositions, and pressed California plants.

At the first Rochester (N.Y.) show physicians came to look, returned a few hours later with exhibits concealed beneath their coats, and asked permission to show them!

Advance notices are usually inserted in the county, state, or local medical bulletin. These notices include the name and address of the person to whom entries should be sent.

Sometimes an entry blank is printed in the bulletin, along with the announcement. Sometimes blanks are mailed separately instead to those who request them.

On his blank the exhibitor writes his name, address, and phone number. Quite often, also, he is asked to describe the exhibit and indicate the amount of space required and the type of space—whether wall, floor, table, or case. An appraisal of value has also been found useful. There are no fees, as a rule, and no judges.

Subsequent bulletins carry final plans for the show. Chicago used cartoons with telling effect.

If the public is not admitted, extensive newspaper publicity is unnecessary. All groups have received such publicity, though, anyway. Publication of both write-ups and pictures is almost inevitable because the idea is a novelty. The Cleveland *Plain Dealer* had a full page of pictures in the Sunday rotogravure section. All papers in the San Francisco Bay region publicized the Oakland show.

Other means of entry stimulation are also effective. One group makes inquiry through personal acquaintance as to the hobby interests of doctors and their wives. When the auxiliary manages the show, wives and immediate members of families sometimes exhibit, too.

At the show staged last month by the New York State Medical Society during its annual meeting, visitors registered, were conducted personally through the show, and were questioned about their hobby interests. Notes were made of this information. If the visitor did not have a hobby, one was encouraged.

There is no set time for a hobby show, though exhibits are usually

run in connection with some highlight event, such as an annual state convention. It is almost always a featured affair, sometimes with a well-known outside speaker.

Time, place, and length of the show depend somewhat on the occasion. A show at a state convention may run the duration of the meeting and is likely to be held in the convention hall or hotel.

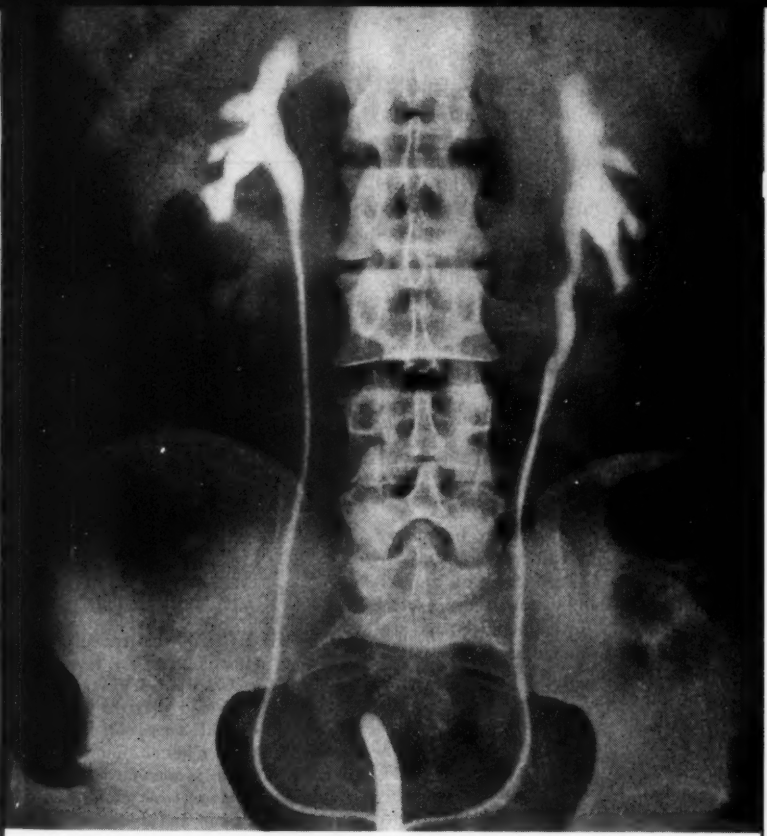
Where possible, exhibits are set up in a separate room—sometimes close by the scientific displays. The local academy or medical association building is another favored show place. Chicago used the patio of the Sky Restaurant of the Medical Arts Building. For the Oakland show, the California College of Arts and Crafts donated its exhibit room.

Hobby shows have run from one evening to two weeks. Next year Los Angeles plans a three-week show; the first week is to be devoted to art, the second to handicraft, the third to collections. From two to three days or evenings, as the case may be, is the usual average.

Most exhibitors are held responsible themselves for transporting and setting up their displays, although Detroit did employ experienced men for the purpose. Exhibits are generally in place by the day before the opening. They are left intact during the show and removed by the evening of the day following its close. Displays may be transported by express, by mail, or in the cars of owners. Careful packing, insuring, and a clearly-marked label giving the owner's name, address, and description of the exhibit should always be required.

Public interest is so keen that most groups have found it necessary to admit at least a part of the public to some portion of the show. Physicians' families, of course, are always admitted. Los Angeles limits outsiders to friends of physicians and their families. Other groups set aside one evening or one day for the general public. Oakland, Chicago, and the Physicians' Art Club of New York admit any and all comers for the entire show.

Naturally this increases the risk. Chicago had Pinkerton men on guard throughout the exhibit. Marshall Field & Company donated locked, glass cases. Cleveland has police protection for its shows, and exhibitors are required to stand guard over their displays. Oakland arranged for a special police guard after the exhibits were set up; while, during the show, the women's auxiliary acted as hostesses and kept eagle eyes peeled. Oakland also took out $20,000 insurance on its first show in March. That provided a maximum coverage of $250 for any one object. In addition, a $50,000 liability and property damage policy was taken out to avoid possibility of trouble from accident to visitors. Los Angeles took out a blanket fire and theft policy for



40 Principal Conditions May Cause Trouble Here

THE problem of diagnosis and differentiation assumes commanding proportions when the urinary tract is involved. But efficient use of the x-ray examination has contributed mightily to the present-day accuracy with which urinary disease may be diagnosed and classified.

Simple radiography will outline the kidneys, indicating their size, shape, and position.... Pyelography will disclose calculus, sarcoma, tuberculosis, alterations in the renal pelves signifying hydronephrosis; also kinks in the ureter or obstruction.... Retrograde urography will demonstrate the presence of tumors, traumatisms, diverticuli, foreign bodies. In differential diagnosis, radiography will usually place the blame where it belongs.... The radiographs, by the facts they disclose, will suggest proper therapeutic procedure.

For utmost assurance of accuracy in diagnosis, every sufferer from urinary disease is entitled to an early, comprehensive radiographic examination. Eastman Kodak Company, *Medical Division*, Rochester, N. Y.

$9,000, based on an itemized appraisal submitted by the exhibitors.

Wherever hobby shows for doctors have been held, they've created widespread interest. Entries have run from thirty to over 200. Attendance has been from a few hundred to several thousand.

Such shows widen one's interests. They promote better feeling among the doctors who see them. Rivalries and jealousies are hard to maintain when a fellow shares your hobby interests.

Hobby shows have civic and social effects, too. Wives have broadened their social activities very happily through contacts made at them.

Sometimes they even have far-reaching community results, as in Rochester (N.Y.) where an annual city-wide hobby show has grown out of the project, and plans are on foot to provide a modern medical museum under the supervision of the Museum of Arts and Sciences!

If you don't already have a hobby —get one. For sooner or later there'll be a hobby show for doctors at which you'll want to exhibit.

CARTONS in which 20-cc. ampoules are delivered make useful containers for test tubes. I find that specimens sent to a laboratory in such a carton get there without breaking.—STEPHEN F. HALE, M.D., Mobile, Alabama.

PHONE NUISANCE CURED

I HAVE TWO TELEPHONES in my home office—one in my consultation room, the other in my family's living quarters. I used to be plagued continually while in my office by phone calls for members of the household. Repeatedly I would answer the phone only to find out that it was for my wife, for one of my children, or even for the maid. Whereupon I would have to leave my office to summon whoever was wanted.

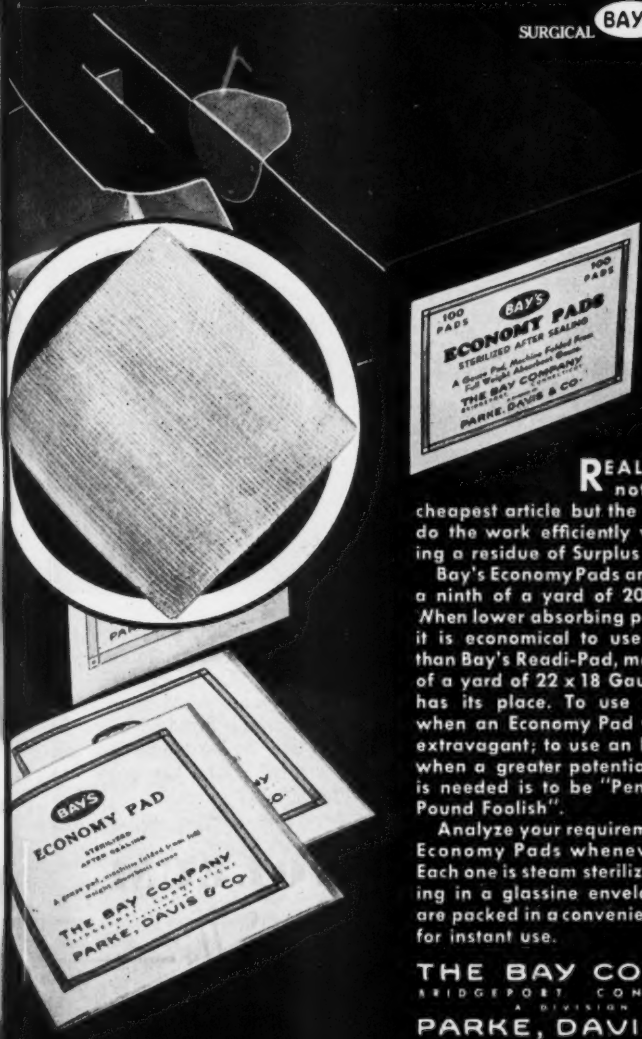
Sometimes, while busy in my examining room, I would be unable to answer the phone. Consequently, the call would be taken in the living quarters of the house. If it was for me, someone would have to come through the waiting room to tell me so. Since I have no secretary, this was a severe nuisance.

I put an end to all that recently by investing a few dollars in a two-way buzzer system. Now, if I answer the phone first and find that the call is for someone in the household, I merely press my buzzer button. Conversely, if a call for me is answered by the maid or by some member of my family, they buzz me and I answer the phone at my convenience.

This little improvement in my telephone system (installed by the phone company) has spared me considerable annoyance. It has also done away with embarrassment to myself and my patients.—LOUIS PENN, M.D., NEW YORK CITY.

FOR ECONOMY OF UTILITY USE BAY'S ECONOMY PADS

SURGICAL BAY'S DRESSINGS



REAL economy is not to buy the cheapest article but the one that will do the work efficiently without leaving a residue of Surplus Utility.

Bay's Economy Pads are folded from a ninth of a yard of 20 x 12 Gauze. When lower absorbing powers will do it is economical to use them rather than Bay's Readi-Pad, made of a sixth of a yard of 22 x 18 Gauze. Each Pad has its place. To use a Readi-Pad when an Economy Pad will satisfy is extravagant; to use an Economy Pad when a greater potential absorbency is needed is to be "Penny Wise and Pound Foolish".

Analyze your requirements and use Economy Pads whenever possible. Each one is steam sterilized after sealing in a glassine envelope, and 100 are packed in a convenient box, ready for instant use.

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INVESTORS' CLINIC

BY FRANK H. McCONNELL

STOCKS are now moving forward. Blue days in Wall Street are over. Soon the brokers who a short time ago were closing branch offices and giving pink slips to worried workers will be asking for more clerical help to take care of incoming orders.

Thanks to new rules laid down for the public's benefit, the "little man" was not hurt in the recent shake-up. Paper profits did vanish, it's true; but actual losses were relatively small.

The people hurt most were those of fairly large means who transferred cash balances to Amsterdam and London, through which money centers they made purchases of stocks here. They were able over there to buy large blocks of stocks on comparatively small margin since the rules in those centers are less strict than in this country. As a result, their losses were proportionately greater than those of Mr. Jones and Mr. Smith who were obliged in American markets to put up 55 cents in cash for every dollar of stock they bought.

Naturally, there was some grousing about the stringency of the rules when they were first adopted. But in the first major market test their merit was proven. Mr. Jones and Mr. Smith still have their shirts.

U. S. Rubber Company

Not the natives who tap the trees for latex, but the tire makers, will benefit most from this year's price rise in crude rubber.

Convertible Bonds

While common shares were slipping downward, convertible bonds scored an interesting victory. In a majority of cases they advanced appreciably.

Convertible bonds were suggested recently in this department as an inflation hedge. It was explained that bonds of this type—which can be exchanged for common stocks at the option of the owner—have a two-fold advantage: (1) They rank ahead of the common stock of the company that issues them and therefore give a greater measure of security to the investor; moreover, (2) they give the owner a chance to share in an upward movement if the common stock of the company happens to soar.

With inflation here—though not

yet the rabid kind that people picture when they think of the German experience, stocks naturally have a preference over bonds. They are more volatile and are quicker to rise. Consequently, bonds which may be converted into stocks have much the same quality as stocks, although their risk is less.

Tire Makers Profit

Leaders in the business of manufacturing automobile tires are unusually cheerful these days. More people are traveling and prices are better. Ordinarily, motor manufacturers allow only a small margin of profit to tire makers; but this year has been a notable exception.

For one thing, crude rubber from which tires are made is currently higher in price than it was in 1936. Tire makers are reaping a benefit since they bought their supplies of crude rubber last winter and can now make an extra profit on their finished product.

For another thing, all commodity prices have been rising. Leather, rubber, wheat—almost everything used in everyday life—has gone up. Automobile manufacturers have been quick to recognize that trend, and they have not hesitated this year to pay a little more than they did two or three years ago.

In view of this improvement after several years of laggard prices, an investment in the tire and rubber industry would seem to have genuine merit. Shares of the stronger companies in the field are well worth the consideration of physicians who wish to add to their holdings at this time.

Hard-Working Distilleries

After a long tussle brought about by too much competition, the producers of hard liquor have at last reached a point where they feel fairly contented with their prospects. Naturally, they would like to see fewer companies in the field. Nevertheless, leaders in the industry admit privately that their outlook for profits has distinctly improved.

In January there was a sharp rise in hard liquor stocks. Retail prices dropped soon afterwards and sales rose. August, therefore, finds most of the nation's distillers with comparatively small inventories on hand.

Because of this fact and because people have more money today than they had six months ago, a concerted effort is being made to stimulate production. Under such conditions, the common shares of the stronger companies are naturally in a position to benefit.

Bank Shares Hold Up

One of the more disturbing factors in banking circles recently has been the consistent decline in U. S. Government bonds. Banks have noticed this decline particularly since their purchases of government bonds have always been sizable.

Naturally, when an institution

holding, say, $100,000,000 worth of government bonds suffers a loss of even a quarter of a point, the toll is heavy. A quarter of a point (one fourth of one per cent) on that sum means the tidy figure of $250,000.

Lately, however, bankers have found balm in Giliad. Although their government bonds have dropped somewhat, people are more anxious to borrow money than they were a few months ago. Consequently, interest rates have advanced.

Thus far, the rise in interest rates has probably not quite equalled the paper losses on government bonds; but the trend is distinctly favorable. Banks, after all, make most of their profit on the money they lend—not on the bonds they hold. For that reason, the present upswing in money rates—which influences bond prices—is helpful to banks.

Holders of bank stocks have little reason to sell their shares yet. In fact, additional purchases are justified in the securities of the stronger institutions.

A DISCOUNT DOES IT

I HAVE EVOLVED a simple method for improving collections. I offer patients a discount of 20% for cash at each call, stating that the reduction is justified as it eliminates bookkeeping and sending out statements. This gives me an insight as to whether or not patients intend to pay. If they take advantage of the offer, they would probably have paid anyhow. If they do not, I know that their credit needs investigation and that more than normal pressure will probably have to be applied in the collection of their debt. —SAM H. HITCH, M.D., DALLAS, TEXAS.

UNDER THE

BY GLEB BOTKIN

ARTICLE 120 of the newly promulgated constitution of the U.S.S.R. (Soviet Russia) states:

"Citizens of the U.S.S.R. have the right to maintenance in old age and also in case of sickness or loss of capacity to work. This right is ensured by the wide development of social insurance among workers and other employees at state expense, free medical service, and the wide network of health resorts at the disposal of the toilers."

Soviet Ambassador Troyanovsky states in one of his speeches that although physicians in Russia "in their outside time may, if they wish, treat private patients and receive fees . . . practically the entire population has its health needs taken care of through the widespread social insurance system, which is a charge on the place of work, not on the individual."

He states further in the same speech that Soviet physicians themselves prefer to hold several salaried positions instead of engaging in private practice, but that at present they are no longer allowed

(Left) Three generations in pictures. Top: Professor Sergius Botkin, "father of Russian medicine." Center: Czar Nicholas II; Dr. Eugene Botkin, his personal physician; and friend. Bottom: Gleb Botkin, author and theologian.

to do so, "except in special cases by government decree."

Is there anything particularly radical or unusual about the Soviet medical system? The statement that the cost of social insurance guaranteeing free medical service is a charge "on the place of work, not on the individual," makes one wonder how "the place of work" balances its budget. In practice there would seem to be little difference between having a part of one's salary deducted for health insurance or being paid a smaller salary and given health insurance free.

The main difference between the

SEVERAL COMMENTARIES *on medical practice in Soviet Russia have been written by visiting tourists—people who spent but a short time in the country and were shown, presumably, its best features. Mr. Botkin is no tourist. On the contrary, he has lived for many years in Russia and comes from what is probably the country's most distinguished medical family. For those reasons alone, his views are both seasoned and authoritative.* ¶ *The place occupied by the Botkins in Russian medicine and their relation to the former Imperial Court are particularly interesting. Professor Sergius Botkin, grandfather of the author, is generally referred to as "the father of Russian medicine." While professor of internal diseases at the Medical Academy of St. Petersburg, he achieved national fame. His statue in Leningrad today is among the few monuments left intact by the revolutionaries. Many clinics and hospitals still bear his name. Sergius Botkin was a close friend and the personal physician of Emperors Alexander II and Alexander III.* ¶ *Professor Botkin's son, Eugene (father of the author), likewise attained prominence as a physician. During the Russo-Japanese war he was appointed commissioner-in-chief of the Red Cross. In* 1908 *he accepted the position of personal physician to Emperor Nicholas II. After the revolution of* 1917 *he followed his sovereigns in exile to Siberia and was murdered with the Imperial Family by the bolsheviks in Ekaterinburg on July* 17, 1918. ¶ *Gleb Botkin was born in* 1900. *Being too young to join the army in* 1914, *he worked in the hospital organized by his father. Theology, however, not medicine, turned out to be his basic interest. After remaining for some time with the Imperial Family in their Siberian exile, Mr. Botkin finally escaped to Japan. In* 1922 *he was offered the post of a mitered archpriest in charge of the Diocese of Kamchatka. He declined, however, and began writing professionally. He came to the United States in that same year and has lived here ever since. Gleb Botkin has written six published books and has contributed to numerous American magazines and newspapers.*

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provides two valuable features in the treatment of symptomatic constipation. It creates gentle osmosis to help rid the body of intestinal waste—safely and thoroughly. It also helps to raise systemic resistance by aiding in the maintenance of the tissue-plasma alkaline level.

New experimental evidence indicates that Sal Hepatica stimulates an increased rate of bile flow from the gall bladder into the duodenum.

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situation in Russia and elsewhere seems to be that in actual practice most Russians use the free service offered them instead of employing physicians privately.

But what kind of free medical service does one get in Russia? To begin with, it does not include visits to a patient's home. If too ill to move, the patient is taken to a hospital; otherwise, he has to go himself to a health station. Under no circumstances does the physician come to him.

Furthermore, a Soviet citizen applying for free medical treatment cannot go to just any doctor he happens to like. He has to go to the health station to which he belongs by virtue of his employment. Thus, there can hardly exist that mutual emotional acceptance between patient and doctor which, as we all know, is a curative factor of tremendous importance.

The same Ambassador Troyanovsky states that every patient "on first applying must be exhaustively overhauled." But he also states that physicians are required to work from five and a half to six hours a day "and the aim is that they should not receive more than six patients on the average in an hour." Thus the "exhaustive overhauling" has to be done in exactly ten minutes.

It could hardly be otherwise when, according to official Soviet statistics, there are only 80,000 doctors in the Soviet Union, working for a maximum of six hours a day and serving a population of 180,000,000. Taking into account holidays, rest days, and absence from work because of illness, a simple arithmetical calculation reveals the fact that a physician can hope to give in the aggregate only from thirty to forty minutes to each of his patients per annum.

Before attempting any conclusions, it is necessary to say a few words about the status of medicine in pre-revolutionary Russia. It is a mistake common to many commentators on the Russian situation to regard Soviet Russia as something that has suddenly dropped down from the moon. Needless to say, the Russia of today is but an outgrowth of the Russia of yesterday; indeed, in many of its aspects it seems to be a return to the Russia of the day before yesterday.

First of all, it must be taken into consideration that Russian medicine is but an infant. How very young it is can well be judged from the fact that my own grandfather, Sergius Botkin, who died only in 1889 at the age of 57, is usually referred to as the "father of Russian medicine." Before him, medicine in Russia was entirely in the hands of foreigners, and was confined chiefly to scientific research and to practice among the upper classes. It was my grandfather who created an entirely new cadre of Russian physicians, as well as made of medicine itself a service for the people and not merely a luxury for the wealthy.

Thereafter medicine in Russia made astonishingly rapid progress. The pre-revolutionary Russian physician won for himself the reputation of being not only an extremely competent practitioner, but also a man of exceptionally high ethical standards.

Russians in general are inclined to be suspicious of money and of any activity which has for its purpose the making of money. It was easy therefore for my grandfather

to impose upon the Russian medical world the viewpoint that medicine was not a profession, but a vocation—a form of public ministry. As such it had been consistently regarded and maintained in Russia right up to the time of the revolution.

There having been no way, under the old regime, of compelling people to choose this or that career, the number of doctors in Russia was pathetically small. By 1913 there were only about 20,000 licensed physicians. They were aided, however, by so-called medical assistants who had undergone special medical training but had not qualified for the status of full-fledged physicians.

Further help was provided by a corps of sisters of mercy. The latter had about the same education as American nurses, but were organized like a lay monastic order. They lived in so-called "communes," each commune having a hospital of its own. The sisters of mercy came from all classes of society, including the highest aristocracy, and were held in great esteem, both for their competence and for their truly astonishing spirit of self-sacrifice. Needless to say, nobody became a sister of mercy for the purpose of making a business career. Theirs was a purely idealistic service.

The pre-revolutionary Russian physician led an heroic life. He had to respond to any call at any time of the day or night.

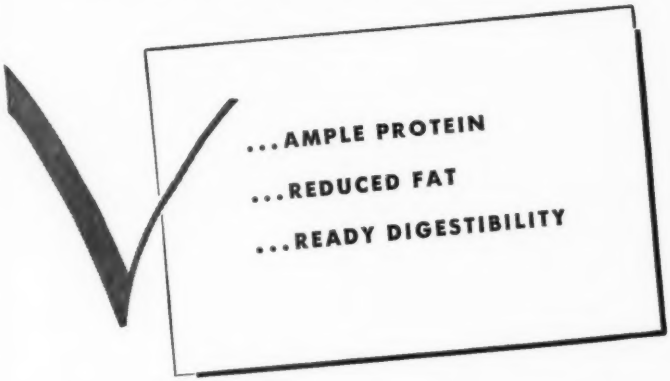
"Illness observes neither hours nor holidays," my father—himself a prominent physician—used to say. "Neither does a doctor."

Furthermore, a doctor was forbidden not only to send bills to his patients but even to hint how much he expected to be paid—indeed that he expected to be paid at all. This was not merely a beautiful theory but a rigidly enforced practice. When in 1913 one of the best known physicians in St. Petersburg was found to have suggested to his patients the amount he expected to receive for his services, my father presented him with the ultimatum of either immediately discontinuing his mercenary activities or of losing the right to practice. He chose the former.

My father himself, I may add, for the last years of his service had only one patient who occasionally paid him; yet he was so busy that he seldom slept more than four or five hours a night.

There was no constitutional guarantee of free medical service; still the only complaints I ever heard about the difficulty of obtaining an appointment with a physician came from the wealthy. While people of power and means were waiting for hours in the reception rooms of the better known

Dryco Modifications check on these formula needs



WHEN you judge the merits of an infant feeding formula, are not these questions foremost:

... Is the protein supply adequate to compensate for the biological differences between proteins of cow's milk and human milk?

... Is the fat level commensurate with the digestional differences between fats of human milk and cow's milk?

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doctors, the latter were treading stairs to attics and basements occupied by the poor who could never afford to pay a cent for the services rendered.

I have often been asked: "But how did Russian physicians live?"

The answer is: "In extreme poverty."

Some of them, of course, had salaries from the Academy, the Army, the Imperial Court, hospitals, schools, and other institutions. A few had achieved such reputations that their wealthier patients were glad to pay fantastic sums only to be received. But the majority were abjectly poor. In 1912 my father told me that many a middle-aged physician with a big practice had to live on as little as fifty rubles ($25) a month.

The wealthier Russian doctors did everything in their power to help their less fortunate brethren. They formed many organizations of mutual assistance within the profession. Even so, the average Russian doctor was unquestionably a martyr to his cause; and, incidentally, his average span of life was only 36 years.

It will be seen that under those circumstances there was no need of any constitutional guarantee of free medical service. There was also no problem of unemployment among physicians; on the contrary, there was an acute shortage of them; and every doctor I ever knew worked not six hours but eighteen and twenty hours a day and knew naught of holidays.

The real problem was how to improve the lot of the individual physician and how to increase the number of physicians. The Soviets have solved it. They have given 90% of the physicians government jobs and they have increased the number of physicians from 20,000 in 1913 to 80,000 in 1935. Regarding the latter achievement I shall again quote Ambassador Troyanovsky:

"To train even this many doctors quickly before we really had adequate facilities has meant a certain sacrifice in the quality of the training."

This can well be imagined.

What, then, has actually happened in Russia? The heroic fraternity of pre-revolutionary doctors has been changed into an army of inadequately trained medical laborers. Today's new doctors do not have the financial worries of their pre-revolutionary predecessors, even though their salaries remain pitifully inadequate. But neither are they likely to have the moral satisfaction of working for a great cause, of becoming benefactors and friends of thousands of grateful people. All they can do is to give "exhaustive overhaulings" to six people an hour. Will they say as my father said to me, at the age of fifty:

"Were you to give my youth back to me, I should run as fast as I

[TURN THE PAGE]

could to the Academy of Medicine. Except for priesthood I know of no calling higher or more satisfying morally than that of a physician."

As for the Soviet citizenry, the fact that most of them use the free medical service exclusively means one of two things. They like it. Or they have no money to employ doctors privately.

Significant it is that when the Soviet potentates themselves get sick they send for foreign specialists. This even the last Russian emperors found it unnecessary to do; indeed, often enough, Russian specialists were summoned for consultations abroad.

Whether the present medical system in Russia is an improvement on the old one or not, it is difficult to see that the medical profession in this country can learn anything from it. Nobody questions the idealism of American physicians, yet the average American doctor is in the final analysis a professional man—not a sort of Franciscan friar. And he is accustomed to a relatively high standard of living. The meagre salary paid the modern Russian physician would certainly mean no improvement in his financial situation.

As for the average American citizen, I'm inclined to believe that even in these days of unemployment, he is far better taken care of medically than the average Russian citizen. Even among the poor of this country I have never come across a situation where a person in case of emergency lacked access to free medical help, whether supplied by a clinic or by some individual physician of a philanthropic turn of mind.

Far be it from me to imply that

the problem of either the physician or the needy sick in this country has been successfully solved. My only conclusion is that it would be difficult to discover in the peculiar Russian situation anything that might contribute to its solution.

BASIC SCIENCE ISSUES

WHEN A STRINGENT basic science law was legislated in Oklahoma this spring, local physicians nodded approval. Then they settled back to await the effects of the law's impact.

They didn't wait long.

It was expected that hardship would be worked on a limited number of embryonic doctors. Therefore, it was no surprise recently when the state's attorney general ruled that medical students of the class of '36, now interning, will have to take basic science examinations even though they have already passed their state medical boards.

Not having completed one year of internship, the youngsters have not yet been licensed to practice in Oklahoma. Now they can't be licensed until they have negotiated basic science requirements.

No surprise either was the Oklahoma Osteopathic Association's charge of discrimination in the first basic science tests given. The osteopaths had fought the basic science law throughout its pre-passage career. Why wouldn't they find fault with the way the provisions of the law were carried out? reasoned the profession.

The accusation of discrimination was made shortly after it was revealed that seven of eight osteopathic students as against only eight of sixty medical students had flunked. (No chiropractors had taken the tests.)

Entirely unlooked for is another issue created by the basic science law.

Dr. M. Shadid, founder and manager of the Farmers' Union Cooperative Hospital in Elk City, has threatened to walk out on his cooperative-medicine project. Furthermore he has broken definitely with his erstwhile ally, Tom Cheek, president of the Farmers' Union. All because Cheek, a political power of sorts, decided a few weeks ago to initiate a bill repealing the basic science law.

The board of directors of the Farmers' Union Cooperative Hos-

B-D YALE SYRINGES

Made of Resistance Glass

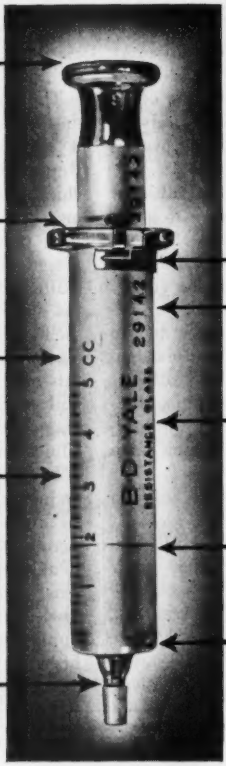
Slightly concave plunger thumb rest provides surer touch

Flared barrel opening receives plunger easily, reduces breakage

Barrel and plunger are individually fitted to each other

Scale pigment is permanently baked into barrel

Tip has glazed groove which eliminates score mark and greatly increases its strength



A dated certificate of accuracy comes with each B-D Yale Syringe

Simple, non-scraping plunger clip retains plunger

Plunger and barrel individually numbered

Careful annealing eliminates barrel strains, reduces breakage

Precision line on plunger aligns with scale for accurate dosage

Reinforced flared barrel end lessens breakage

B-D PRODUCTS
Made for the Profession

B-D Yale Syringes deliver the longest possible length of useful service, for the following reasons: Breakage at tip is reduced because the score mark of the grinding is eliminated and the tip has the full strength of unground glass. Breakage at the barrel base is reduced because the base is flared to eliminate an internal score mark. Every B-D Yale Syringe is tested by the Polariscope for stresses and strains, has a long, tight and smooth bearing surface and is treated to withstand more than 150 hours of continuous sterilization by recommended method (clean, then sterilize with plunger home in barrel).

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

pital met in the absence of Dr. Shadid and approved the proposed bill. Dr. Shadid called the directors together again and asked them to reconsider. They remained adamant. Then, Dr. Shadid announced his intention of resigning from the hospital's board of directors. At this writing, he has not decided whether he will abandon the cooperative medical project entirely or continue with it in a purely professional capacity.

The first paragraph of Politician Cheek's proposed measure to abrogate Oklahoma's new basic science law states: "No applicant for a license to practice the healing art . . . shall be required to take an examination for such license before a board of examiners whose membership does not consist wholly of examiners who are active practitioners of the school of the particular healing art of which such applicant is a member."

Dr. Shadid describes that as open invitation to quacks.

In making his break with Cheek, Dr. Shadid indulged in what many Oklahoma physicians consider sweeping, if not highly imaginative, statements. For instance: "A large part of the medical profession is with us [in the fight for cooperative medicine] whether they say so or not. The time will soon come when they will be with us in the open. They will organize a new medical association in opposition to the medical oligarchy dominating the American Medical Association."

The basic science act passed by the Michigan legislature last May is threatened with a referendum. Representative Hans Ole Clines, chief legislative opponent of the measure, has revealed that Michigan chiropractors and osteopaths are planning to circulate petitions calling for submission of the law to the state's citizenry.

"I feel that excessive pressure was placed upon the legislature for this enactment and that the people will not approve if they get a chance to express themselves," Clines has asserted.

In order to bring about a referendum it will be necessary to distribute a petition and file it within ninety days of the legislature's final adjournment. To be valid, it must carry 95,000 signatures. If filed, such a petition will stay the application of the act until it has been popularly approved at the next general election in November, 1938.

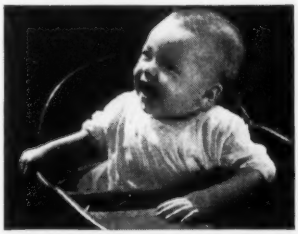
Highchair tantrums nipped in the bud!

Patricia at 4 months

At this age Patricia had already been introduced to Clapp's Baby Cereal and was about to have Clapp's Strained Vegetables added to her diet. She learned to know and like the flavors of all the important protective vegetables so early in life that she has displayed a calm acceptance of them ever since.

Patricia at 7 months

By this time Patricia was also getting Clapp's Strained Fruits. She had grown an inch, gained more than a pound a month and started to creep. Her sturdy body indicated a plentiful supply of vitamins and minerals from her Clapp Foods, grown from selected seed and pressure-cooked.



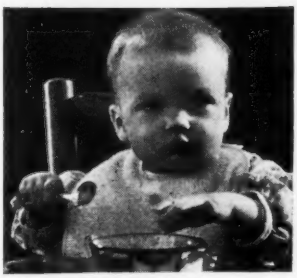
Patricia at 10 months

She took her first steps at 9 months, and at 10 months she could walk. She was 30 inches tall and weighed 18 pounds, 12 ounces.

• • •

Patricia is now past two years old, with an affable appetite. The same report comes again and again concerning Clapp-fed babies . . . they adjust easily to adult diet.

Clapp Foods are finely strained, but not too liquid. Each vegetable has its own distinct flavor, so that there is no difficult transition later on, as so often happens when a child becomes habituated to vegetables only in combination.



16 VARIETIES

Soups: Baby Soup (Strained & Unstrained), Vegetable Soup, Beef Broth, Liver Soup.

Vegetables: Tomatoes, Asparagus, Spinach, Peas, Beets, Carrots, Green Beans.

Fruits: Apricots, Prunes, Applesauce.

Cereal: Baby Cereal.

FREE: Comprehensive booklet of recent findings on Infant Feeding. Address Harold H. Clapp, Inc., Dept. 614, 1328 University Ave., Rochester, N. Y.

Clapp's Strained Foods

THE ORIGINAL STRAINED BABY FOODS

PROTECTION OF VITAMIN C IN CANNED FOODS AGAINST ENZYMATIC DESTRUCTION

● One of the unusual features of modern food preservation by canning is the high degree of protection afforded vitamin C during the canning procedure. Of all the vitamins, C is probably the most readily destroyed. Spinach, for example, will lose one-half its vitamin C content upon standing three days at room temperature and practically all of its antiscorbutic potency in seven days' time (1).

Oxidation is the principal factor operating in the destruction of vitamin C. The rate of oxidation depends — among other things—upon temperature, degree of exposure to oxygen, and presence of substances which catalyze the oxidation reaction. Chief among the catalysts is the enzyme known as ascorbic acid oxidase. This enzyme is instrumental in the loss of physiologically active forms of cevitamic acid (ascorbic acid) by catalyzing the transformation of this latter substance into dehydrocevitamic acid (dehydroascorbic acid), which is more readily decomposed by a non-enzymic reaction into a compound having no antiscorbutic activity. This enzyme is apparently widely distributed in the vegetable kingdom, having been found in cabbage, carrots, lima beans, parsnips, peas, pumpkin, spinach, squash, string beans, sweet corn and swiss chard. Fortunately, the cevitamic acid oxidase is completely inactivated by heating to 100°C. for one minute (2).

In modern canning practice field crops are harvested at the optimum stage of maturity and canned as rapidly as possible—usually within a few hours' time. Early in every canning procedure the product receives either a blanch or a pre-cook or exhaust, the primary purpose of which is to drive out air from biological tissues and to establish a vacuum by expanding the contents of the can by heat, contraction upon cooling resulting in a partial vacuum within the can. These preliminary heat treatments together with the heat process serve both to destroy oxidative enzymes and to remove most of the air from the can.

Thus, the various practices in the canning procedure combine to afford excellent protection for this most labile accessory food factor known as vitamin C.

AMERICAN CAN COMPANY
230 Park Avenue, New York City

(1) 1936, Food Research, 1, 1 (2) 1936, J. Biol. Chem., 116, 717

This is the twenty-seventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. What phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. Address a post card to the American Can Company, New York, N. Y.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

AN INSURANCE PROGRAM FOR THE PHYSICIAN

The third in a series of letters to a young doctor, explaining what the well-rounded insurance portfolio should contain.*

DEAR BOB:

So far, this insurance prescription I've been writing for you has specified four ingredients:

1. An accident policy providing $200 a month for life in the event of accidental injury.

2. Term insurance on your life, to age 65, in the amount of $10,000.

3. A $10,000 ordinary (whole) life insurance contract.

4. Disability coverage bought in connection with your ordinary life policy, providing a $100-a-month non-cancellable income without time limit in the event of a disabling illness or accident.

These policies during your early thirties demand a total annual outlay of between $450 and $500. Quite an item, I'll admit. Yet it constitutes the backbone of your insurance program and embraces only the absolute essentials. No money has been allotted to fancy but relatively worthless frills.

In this letter I want to review for you in its several forms the next most important type of coverage, namely: *liability* insurance.

Take malpractice. The possibility of a malpractice suit—even though such suits are rarely justified—is an ever-present menace. The physician who foregoes malpractice insurance also foregoes his peace of mind.

For the young man in medicine this is vital protection since his chances of error and, therefore, of being sued are relatively greater. Malpractice insurance represents equally vital protection, too, for the doctor who has "arrived," because his success suggests ready money to the unscrupulous patient who seeks to wriggle out of a medical bill by instituting suit for malpractice.

When buying this form of insurance, make certain that the following two questions can be answered satisfactorily:

1. Does the contract agree that the company will settle *only* with the written permission of the defendant doctor? It should. After all, what you want from malpractice insurance is defense of your professional reputation right up to the court of last resort. Settlement of a claim against you without a fight implies an admission of guilt on your part. That, of course, is always bad. [TURN THE PAGE]

*The first appeared in April; the second, in June.

2. Is the negligence of any assistant (generally a nurse) whom you employ assumed under the contract? It should be. If a patient gets a burn during the course of a diathermy treatment given by an assistant, you may well find yourself the defendant in an action started by the patient. Unless your insurance contract is drawn to cover the assistant, you will find yourself in the uncomfortable position of being entirely unprotected.

A less significant but nevertheless recurring question among physicians who contemplate malpractice coverage is "What limits shall I carry?"

The percentage of successfully prosecuted suits against the profession is small. Large verdicts are rare. Consequently, for the general practitioner at least, minimum limits are likely to be sufficient.

Should you later begin doing a lot of major surgery, particularly bone surgery, I suggest that you boost these limits above the conventional $5,000/$15,000 minimum. The same holds true if you should engage in any other specialty involving more than average risk to the patient.

Malpractice rates are not standardized. The location in which you practice determines to a large extent how much you have to pay. New York City rates are the highest in the country. There $28 a year buys you the minimum $5,000/$15,000 policy. Each year you get a dividend of 20% or better, bringing your cost down to about $22.40.

Now and then I come across a physician who has the impression that malpractice insurance covers any accident on his premises. This is not true. It affords protection

Accepted . . .

MEYENBERG EVAPORATED GOAT MILK

Announcement is made of the acceptance of Meyenberg Evaporated Goat Milk by the Council on Foods of the American Medical Association.

Careful control from the selection and care of the goats to the packaging of the finished product assures a pure, uniform item of food, of high nutritive value and pleasing to the palate.

Because of its different protein chemistry and high unsaturated fatty acid content, Meyenberg Evaporated Goat Milk will often be found useful in infantile eczema and other allergic cases traceable to lactalbumin, or protein sensitivity, of cows' milk.

Available in 14 oz. can through high-grade grocers and druggists.

Clinical sample, descriptive literature and name of nearest dealer sent on request.

MEYENBERG GOAT MILK

GOAT MILK PRODUCTS COMPANY

1039 South Olive Street
Los Angeles, California

only against "professional errors or mistakes committed...by the insured in the practice of his profession and/or by any assistant..."

To be adequately protected against accidents occurring in or about your premises, you really need two other types of coverage: (1) compensation insurance and (2) public liability insurance.

A compensation policy protects you against legal action by a secretary, nurse, or domestic servant for disability arising out of an occupational accident. If you have such a policy, your employees can not institute negligence actions against you. They must accept the benefits provided by compensation statutes and paid by your insurance company.

In some states compensation insurance is compulsory. I suggest that you check on this in your own locale.

Premiums for compensation policies vary in two ways: geographically (according to states) and by scale (according to the employee's wages). In New York, where rates are perhaps the highest, $20 a year will buy coverage for a beneficiary with a moderate salary.

Compensation insurance is granted for disability, not for injury. Furthermore, it covers only your employees.

Public liability insurance is different. It protects you against law suits arising out of accidents sustained by people in general who have occasion to be on or about your premises. It covers such persons as the milkman, the grocery store delivery boy, friends, canvassers, and—most important—your patients.

Here, again, rates vary according to the territory in which you practice. They vary also with relation to the type and size of the building you occupy. The cost, however, is small and can be reduced still further by purchasing your policy on a three-year basis.

If economy must be the keynote of your insurance program, public liability insurance is really less necessary than malpractice or automobile liability coverage. In addition to your malpractice policy, make sure you have automobile liability coverage as well. It ranks in importance with malpractice as peace-of-mind insurance and outranks it by a wide margin as a protective measure against possible suits for negligence.

Contrary to popular impression, automobile liability insurance is not

entirely standardized. See to it, therefore, that your policy protects you against "the liability of *anyone* driving your car with your permission, expressed or implied." This is called "omnibus coverage." Its presence or absence in the contract does not affect the premium you pay.

Another point worth bearing in mind is that your automobile liability policy covers you only while your car is operated within the United States or Canada. Don't take a trip to Mexico during the summer and assume that you are protected. You're not.

Automobile trailers are rapidly coming into favor. Should you acquire one, remember that your liability insurance does not cover you when a trailer is attached to the car unless you pay an extra premium for this hazard.

As in the case of any form of liability insurance, the question again comes up: "What limits to carry?" Although this must be answered with regard for one's own feelings in the matter, let me advise you against excessively high limits. Even in the face of daily newspaper accounts of automobile accidents resulting in suits for fabulous sums, remember that it isn't how much you're sued for that counts, but how much the final judgment is for (generally only a fraction of the amount of the suit).

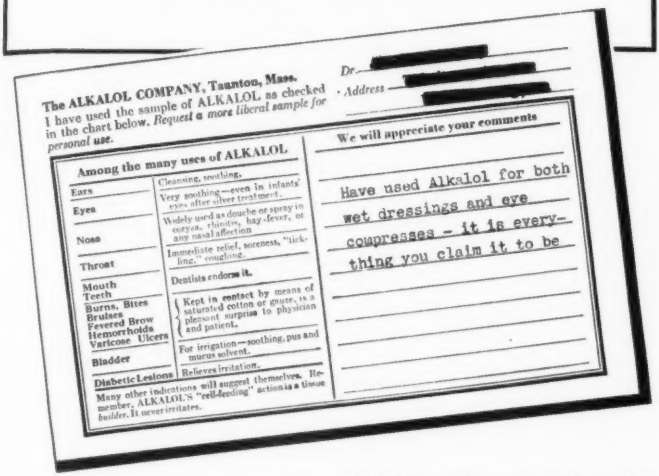
A good many of the larger companies have combined to maintain uniform rates. Nevertheless, reliable, substantial companies are to be found which charge less than standard rates yet provide essentially the same policy benefits. By making a judicious choice of companies, therefore, you can save yourself money each year.

Sincerely,
W. CLIFFORD KLENK

A TIP ON PIPETTES

PHYSICIANS WHO have formed the exemplary habit of taking blood counts on all new patients may be bothered by the solution drying on the tips of used pipettes before they can be cleaned. Removing coagulated material from the pipette then becomes a time-consuming, tedious business. I have found a simple expedient to prevent that. I simply stand my pipettes tip down in a test tube. The solution runs out into the bottom of the test tube, keeping the pipette tip moist and, therefore, open.—WILLIAM R. CHAMBERS, M.D., NORWOOD, OHIO.

CLAIM CHECK!



It's a pleasant thing when the claims you make for a product are checked almost daily by cards like this from physicians, dentists, and nurses! These voluntary testimonials will mean more to you than what I can tell you about Alkalol. Here are quotations from some of the cards I've received—

ALKALOL AVOIDS ADDITIONAL IRRITATIONS

Nasal or oral cleanliness is no problem when Alkalol is used, for Alkalol is a pus and mucus solvent, allays irritation, reduces congestion and has a pleasant refreshing taste and odor. Different from the germicides so much exploited for oral hygiene, Alkalol can be used full strength in eye, ear, nose, wounds or burns, rash or irritation.

Let me tell you what physicians have written for many years about Alkalol in absolutely *unsolicited* testimonials—"Wonderful success with Alkalol in treating and preventing head-colds" . . . "Results amazing" . . . "Wonderful in the treating of inflammation anywhere" . . . "Patients find it comforting and soothing" . . . "It has been my winter stand-by for 15 years" . . . "It fills your statements beyond a doubt" . . . "Finest nasal douche I ever used" . . . "Very efficacious in treating head-colds" . . . "Perfect for treating irritations of the mucous-membrane" . . .

SIMPLE TEST TELLS VOLUMES

Let me send you a free eye-dropper bottle of Alkalol. Then try it in your own eyes. Alkalol has such a wonderful soothing, healing action on the delicate membrane of the eye that it has been used for years to clear the eyes of infants after silver treatment.

Doesn't it stand to reason, Doctor, that if Alkalol has been so successful in treating such a supersensitive organ as the eye that it must be equally efficacious as a douche or spray in coryza, rhinitis, etc.?

* * *

Please remember that Alkalol is a delicate product and should not be dispensed from opened containers. Prescribe Alkalol in original 8 or 16 ounce bottles.

Your card or letterhead will bring a FREE SAMPLE of Alkalol.

(Signed)

J. P. WHITTERS

The ALKALOL Company
Dept. MH7
Taunton, Massachusetts

ARE YOU AN EMPLOYER?

PHYSICIANS WHO employ one or more nurses or other assistants in their professional work are subject to drastic penalties for failure to make tax returns required by the Social Security Act.

Title VIII of the act levies a 1% income tax on every medical office employee. It also imposes a 1% excise tax on the payroll of the employer.

The employer is required to deduct the employee's tax at the time wages are paid. This tax and the payroll tax which he himself pays must be remitted to the Collector of Internal Revenue during the month immediately following that in which the wage deductions were made. The law requires that tax payments be accompanied in each instance by Treasury form SS-1.

Penalties for delinquencies are levied against the physician, not against his employees. These penalties range from 5% to 25% of the tax due, depending upon the period of delinquency.

Physician-employers are also required to file Treasury forms SS-2 and SS-2a. SS-2 shows taxable wages paid to *all* employees; SS-2a shows taxable wages paid to *each* employee. These forms are supposed to have been filed with the Collector of Internal Revenue by July 31, 1937. The first filing covers the first six months of this year. Henceforth, filing dates will be established at regular quarterly intervals.

I. C. S. MEETS

Unawed by Dr. Morris Fishbein's editorial bull in the *Journal A.M.A.* (issue of June 20, 1936) stigmatizing the newly-formed International College of Surgeons, members of the U. S. chapter of the college held their first annual convention recently at the Waldorf Astoria in New York City.

Since the time of its founding two years ago in Geneva, Switzerland, the college has been working toward a twofold objective: to elevate standards of surgery throughout the world and to blast international barriers of prejudice erected during the past decade.

Said Dr. Andre Crotti, of Columbus, Ohio, speaking at the meeting: "It [the college] feels that it can be a medium by which will be brought

ORAL VIGILANTES

Place it in a glass of water, and instantly Vince releases nascent oxygen. Into crevices difficult to reach otherwise in the oral cavity, this oxygen penetrates, cleansing, deodorizing, disinfecting. Potent as an antiseptic—yet mild and harmless when properly used as a mouthwash and gargle. Vince is effectively employed in infections of the oral and nasal cavities and the throat, in Vincent's infection, tonsillitis, rhinitis. Vince is available in tins of 2, 5 and 16 ounces. A trial supply gladly sent on request. Please write on your letterhead.

VINCE

VINCE LABORATORIES, INC.
115 West 18th Street, New York City

THE OXYGEN-LIBERATING ANTISEPTIC

ENERGY IN THE GROWING CHILD

The average child requires a highly nutritious diet to maintain a normal supply of strength and energy during growth. Milk and other good foods are often lacking in essentials which must be derived from another source. As a supplement to the regular diet, Neobovinine with Malt and Iron provides an abundance of the anti-anemic factors, liver and iron, in addition to a palatable malt to sharpen the appetite. Prescribe Neobovinine with Malt and Iron for several suitable cases. You will be pleased with the results . . . . Requests for samples will be promptly filled when written on your letterhead.

THE BOVININE COMPANY • CHICAGO, ILLINOIS

about better understanding among surgeons of the various nations of the world. Since these surgeons will represent an intellectual elite they should be a great influence in their respective countries."

One thousand of the world's leading surgeons are to be chosen as regents of the college. They will examine candidates for membership, demanding that they have adequate training. As a result, it is believed by members of the college that a "licensed surgical aristocracy will be created to contrast sharply with the promiscuous and inadequate surgery not so infrequently seen."

One point on which great emphasis was laid at the meeting was that the college in no way competes with the A.M.A. or with the American Board of Surgery. On the contrary, it was pointed out, candidates for membership must meet the requirements of those organizations before being admitted to the college's examinations.

FIVE YEARS—10,000 OPERATIONS

THE CHIEF SURGEON of this hospital (see cut) has been out of college only eleven years, yet in his twelfth year looks forward to performing 1500 operations, all in varied fields, perhaps 500 major, the rest minor. In addition, he will look after medical cases and pay close attention to dental conditions which affect the health of his patients. All of his six assistants work both in medicine and in surgery, and expect to become, like him, good general surgeons.

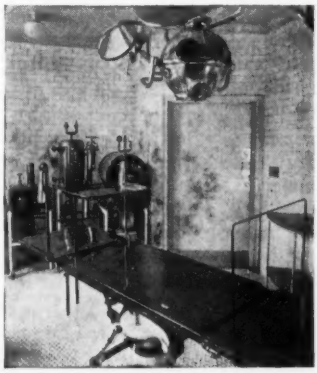
Located near New York City's East Side, the hospital receives only ward cases, having no private rooms at all. Of 8,321 cases attended last year, 75% were charitable. So interesting is the work done that doctors and surgeons from all parts of the world come to visit and observe.

Opened in 1932, the operating room and its equipment represent an outlay of $10,000. A combined x-ray and fluoroscope are in an adjoining room. Almost every case is fluoroscoped, and x-ray photographs are abundant.

Versatility of surgical technique is assured by the variety of injuries and ailments brought to the hospital—many tumors, a good many hernias, as well as simple and compound fractures and conditions of the eye and ear. Emergency operations caused by street accidents are frequent. There is the usual number of Caesarian sections, and unusual number of operations for the removal of foreign objects from the thorax and stomach. No brain surgery whatever is done—a limitation distinctly felt.

Since 1932, of the total of 10,000 operations performed, 250 were caudals—for tumors, injuries, and infections of the tail.

Why, yes. It's New York City's Ellen Prince Speyer Hospital, for dogs and cats.



Watch this blood-study trend!

It's one of the major developments in modern medical practice

EVERY day, apparently, more and more doctors equip themselves to make blood analyses and hemoglobin determinations—because manufacturers of such equipment report sales going phenomenally up.

And from laboratories comes *additional* indication that there is a sharp trend toward greater reliance on blood study—as reflected in the growing number of analyses made.

Many progressive physicians find a modern hemoglobinometer as essential in their work as a good, modern stethoscope, sphygmomanometer—or thermometer: exact, simple and inexpensive. And everywhere, good laboratory service is accessible.

Certainly this is a logical trend—and fully important enough to merit every doctor's thoughtful consideration.

It is known, of course, that anemia co-exists in practically every disease from acne to septicemia. Recent researches show secondary anemia definitely on the increase—further indicating that it is the most common ill of modern times.

Indisputably, exact knowledge of the blood picture is—in every case—a great and valuable aid to diagnosis and successful treatment.

WATCH, ALSO, the centering of professional attention upon the modern hematic known as HEPTOGENE (advertised to the medical profession only). A roborant and reconstructive, HEPTOGENE has well-justified the belief that it could be depended upon to effect an average increase of 500,000 erythrocytes and an average hemoglobin increase of 15 points (Tallquist) *in two weeks—without a single instance of gastric upset.*

FORMULA—HEPTOGENE:

Each tablet represents, approximately: FRESH LIVER—3100 mgm; *FERRUM (Fe")—3.80 mgm; CUPRUM—.13 mgm (precise critical ratio of copper to iron); CALCIUM (as calcium gluconate)—7.00 mgm. PALATABILITY—five-grain coated tablets, easily swallowed whole or crushed in cereals; safe even for infants.

**NOTE* low iron intake—eliminates "heroic iron dosage" with its resultant gastric upset.

MAY WE SEND A PROFESSIONAL SAMPLE—8 full days' supply—with typical case histories involving anemias, under HEPTOGENE medication? Address: *Biobasic Products, Inc., 630 Fifth Avenue, Rockefeller Center, New York, N. Y.*

☆ THE NEWSVANE ☆

WANTED: A "FOLKSY" DOCTOR

Evidence that the old-type country doctor is still dear to the hearts of the average American was received recently by the Oklahoma City Chamber of Commerce in a letter. Bearing the postmark of a small town, it said: "What we want is a doctor all our own. One to whom we can say, 'Dr. Bob, Mary's got the measles. Her fever's pretty high. Can you come right over?' We want a doctor to stroll around our town, join our bridge clubs, drink cokes at Whitey's cafe, and give us pink pills."

Among the assets listed in the letter's description of the doctorless village are two general merchandise stores, three filling stations, one grain elevator, two cream stations, and about 270 "darn swell people."

MORE LAWS AGAINST V. D.

The parade of states marching against syphilis continues to lengthen. Latest to swing into line is Wisconsin. Governor Philip E. La Follette has signed two measures amending his state's laws relating to venereal diseases. One provides for compulsory Wassermann tests for both parties seeking marriage licenses; the other authorizes the state board of health to institutionalize any venereal suspect who refuses or neglects examination by a licensed physician.

The Wisconsin state board of control is authorized to make provisions for the treatment of venereal cases at one or more of the state institutions under its management. Also, one of the amendments permits educational publications acceptable to the state board of health to carry matter relating to venereal disease. Heretofore, only the state's own publications were privileged to disseminate information on that subject.

OBSTETRICIANS CONFOUNDED

Several Oklahoma physicians have decided to think twice or three times before telling a patient that she is sterile. A few weeks ago an Oklahoma farm woman lumbered into a local hospital. She was suffering peculiar pains, she said.

No, she wasn't pregnant. Doctors had told her that it was impossible for her to have a baby. But a few minutes later, as she waited in the library of the hospital, she proceeded to have one anyway.

A nurse, summoned hastily, gasped, "Good heavens, woman, why didn't you tell us you were going to have a baby?"

"Why didn't *you* tell *me?*" came the weak but indignant retort.

FEE NO LAUGHING MATTER

W. C. Fields' witness-stand humor failed recently to deter Superior Court Judge O. K. Morton, of Riverside, California, from a $12,000 verdict in favor of Dr. I. Jesse Citron, small town physician. The sum awarded was for 25 days' medical care rendered in a local hospital last year.

Dr. Citron said that his bill was based on an estimate of one twelfth of the actor's annual income. He added that the handling of the case was

complicated by the necessity for cutting the actor's daily consumption of two quarts of whiskey to but a few ounces a day.

The comedian denied discussing his income with the doctor, stating that only the income tax collector knew his wealth. Said he, "I worry about thinking up gags for my pictures. I let others worry about how much money I have."

As for the drinking charge, funnyman Fields was horrified. "Why," he roared indignantly, "I never drank two quarts of whiskey a day—not even in the good old days."

In handing down the $12,000 verdict, Judge Morton said: "I have never felt that a doctor or lawyer in a small community is entitled to less compensation than one in a large city."

HOW TO WRITE

Medical students at the Wayne University College of Medicine (Detroit) have been given an opportunity to expose themselves to the fine arts of medical writing. Dr. James H. Dempster, editor of the *Journal of the Michigan State Medical Society*, has been appointed to give a series of lectures on the subject. The college claims that the course is an entirely new departure in medical school curricula. Dr. Dempster recently completed and published a 168-page volume titled, *Medical Writing; Some Notes on Its Technique.*

LEPROSY ODYSSEY

Dr. Victor G. Heiser, plague-fighting medical Ulysses, returned last month from a six-month's odyssey to South Africa. While there, he examined over 2,000 of the 80,000 lepers in Basutoland. His trip, he says, has left him fired with enthusiasm for the latest discovery in his favorite pastime of "finding jobs for other people to do"—namely, the raising of a $2,000,000 fund for a world-wide campaign against leprosy. Great Britain has already provided a nucleus for the fund by making the first of a projected series of $100,000 annual contributions.

TRAILER MENACE CHECKED

New Hampshire physicians may soon find additional transient practice coming their way in automobile trailers. The state board of health has adopted a long list of regulations designed to safeguard public health threatened by the advent of trailer fleets. For example:

"This migratory and temporary form of abode, with close and promiscuous living association with others, is a potential factor in the spread of communicable disease." Therefore, all trailer coaches must be accessible to sanitary inspection by agents of the board at reasonable hours. When illness of a communicable nature is suspected, a physician must be called promptly.

Other requirements are as follows:

Now Patients Can "DRINK"

these Important Food Essentials

	1 Ounce of Cocomalt adds	1 Glass of Milk (8 Liquid Ozs.) contains	Result! 1 Glass of Cocomalt and milk contains
†IRON	0.005 GRAM	*TRACE	0.005 GRAM
†VITAMIN D	81 U. S. P. UNITS	*SMALL AMOUNT; VARIABLE	81 U. S. P. UNITS
†CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
†PHOSPHORUS	0.16 "	0.17 "	0.33 "
PROTEIN	4.00 GRAMS	7.92 GRAMS	11.92 GRAMS
FAT	1.25 "	8.53 "	9.78 "
CARBOHYDRATES	21.50 "	10.97 "	32.47 "

★*Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.*
† *Cocomalt, the protective food drink,* is fortified *with these amounts of Calcium, Phosphorus, Iron and Vitamin D.*

DIETETICALLY, Cocomalt, being *fortified* with Calcium, Phosphorus, Iron and Vitamin D, is a "protective food drink" that more and more physicians are using for expectant and nursing mothers, for run-down men and women, for under-nourished children.

Each ounce-serving of Cocomalt provides .15 gram of Calcium, .16 gram of Phosphorus. And, to aid in the utilization of these food minerals, each ounce of Cocomalt also contains 81 U.S.P. Units of Vitamin D, derived from natural oils and biologically tested for potency.

Each ounce-serving of Cocomalt is enriched with enough Iron to supply ⅓ of the daily nutritional requirements of the normal patient... 5 milligrams of effective Iron biologically tested for assimilation.

Thus, with Cocomalt, patients can truly "drink" important food essentials, lacking or deficient in the average diet. And few of them, young or old, can resist the creamy delicious flavor of Cocomalt.

Cocomalt can be taken Cold, or Hot, as you prescribe. And it is easy to obtain at drug and grocery stores in ½-lb. and 1-lb. purity-sealed cans. Also in economical 5-lb. hospital size.

Cocomalt

THE PROTECTIVE FOOD DRINK

Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

FREE...TO ALL DOCTORS

R. B. DAVIS CO., Hoboken, N. J.
Dept. M-8.

Please send me, FREE, a sample of Cocomalt.

*Doctor*_____

*Address*_____

*City*_____ *State*_____

(1) Trailers must be equipped with kitchen and toilet facilities and with suitable water-tight sanitary containers for waste matter. (2) No trailer is to be parked overnight on or near a main highway, nor shall any waste matter be deposited within highway limits. (3) No trailer shall be parked within a hundred feet of any source of public water supply. (4) Adequate screening to prevent fly infestation must be provided. (5) No liquid waste shall be disposed of other than by emptying into a public sewage system, septic tank, cesspool, or manure pit.

Violators of any of the foregoing provisions are subject to a $10 fine.

SPARE HUMAN PARTS

No less an authority than Dr. Walter C. Alvarez, of the Mayo Clinic, has prophesied that once the problem of the prevention of autolysis is solved, surgeons may devote their skill to salvaging vital organs from the newly dead for transplantation into living bodies. Substantiating this augury, he has cited the fact that Russian physicians are "experimenting with red blood cells removed from the dead, such cells being kept on ice until needed for transfusion."

Coincidentally, a recent report from Odessa, Russia, states that Dr. V. P. Filatov has successfully transplanted corneas from human corpses to living eyes in 95 cases. The corneas of the deceased were preserved in a temperature of from 4° to 6° centigrade pending transplantation.

DUTCH COURAGE

From the land of windmills and wooden shoes to Swampscott, Mass. came Dr. K. de Snoo recently to be guest of honor at the annual meeting of the American Gynecological Society. There he declared that if American physicians could prevail upon their pregnant patients to follow the example of Holland's Queen Victoria who bore her children without anesthetics, birth

WE *TRY* TO KNOW IT ALL

ONE of the last activities you'd ascribe to The Borden Company would be running a library.

But, there *is* a Borden Library—one of the most complete private libraries on dairy science in existence.

It comprises 835 books, 2,700 copies of medical and scientific magazines, and more than 13,000 pamphlets and other significant pieces on nutrition, pediatrics, public health, and allied subjects.

These are simply the Library's *latest* figures. Naturally, they are constantly rising.

Naturally—because keeping abreast of published scientific material and having immediately available all the latest pertinent information is one phase of Borden's unceasing effort to know all that can be known about producing and distributing the best and most beneficial milk and milk products.

Borden's 1857 1937

THE BORDEN COMPANY
350 MADISON AVE., NEW YORK, N. Y.

mortality in the United States would be greatly reduced. Only in extreme cases, he declared, do Dutch women—aristocrats or farmers' wives—feel that they should be put to sleep during their "greatest experience."

TO EYE ARCTIC GLANDS

Ubiquitous Dr. George W. Crile times his research to the mercury. In the winter months of last year he penetrated the African tropics. His mission was to scrutinize the thyroids, adrenals, and central nervous systems of tigers, lions, and other big game.

The first of this month, he left on a six-week junket to the Canadian arctic for similar research on seals and walruses. On the basis of results gained from comparative studies of data gathered during the two expeditions, Dr. Crile hopes to pave the way for specialized research along the same lines on humans.

MEDICAL CARE DEARER

The fact that living costs are rising steadily has caused at least one cityful of hospitals to increase its rates. The hospital council of St. Louis, in a survey completed recently, found that during the January-April period of this year, many staple commodities of daily use in hospitals cost from 10% to 79% more than during the same period of 1936. As a result, it has recommended a 5% increase in local hospital rates.

That, the council explains, should help the institutions to maintain their standard of service, although, obviously, it cannot offset altogether the current advance in prices.

Another demonstration of the fact that hospitalization has become dearer is given by the King County Medical Service Bureau, of Seattle, Wash. In its work of providing medical and hospital care on a pre-pay basis to approximately 33,000 clients in employee groups, this bureau has found it necessary to stop supplying free prescription medicine.

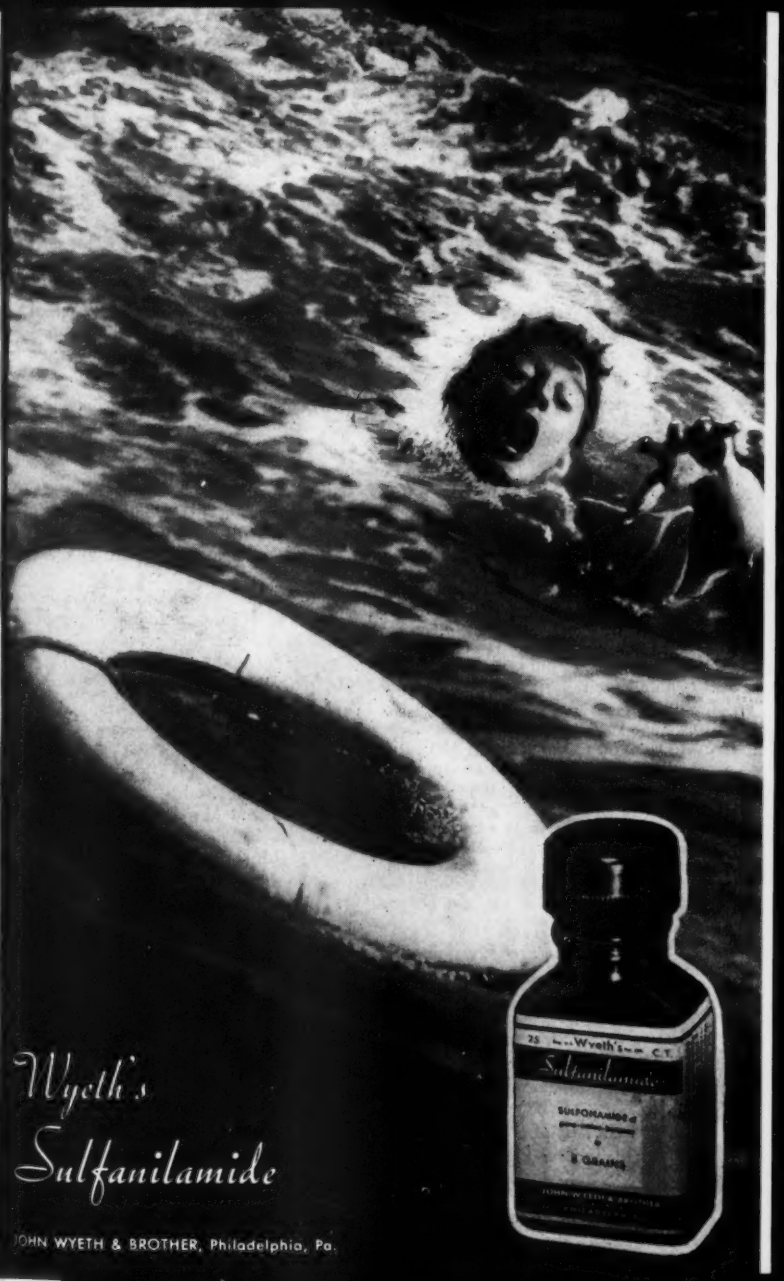
A. J. Johanson, manager of the bureau, explained that because the salaries of hospital employees are climbing to a pre-depression level, the cost of hospitalizing the bureau's clients has gone up too. Consequently, the bureau has had to revamp its income-and-expense ratio. It decided that curtailing the issuance of free medicine would be more acceptable to its members than rising membership rates.

"... IT'S THE UPKEEP"

To 265,000 automobile accident victims, hospitals throughout the country rendered $17,000,000 worth of services last year, according to the American Hospital Association. Of that amount 51% was collected. Total loss: $8,330,000.

SANE JUDGMENT

The approaching trial of Robert Irwin, psychopathic perpetrator of a recent triple murder in New York City, has brought controversy over the relation between psychiatry and the law into the limelight again. Dr. Foster Kennedy, well-known psychiatrist and professor of clinical neurology at the Cornell University School of Medicine, took occasion a few weeks ago to score the existing system of bi-partisan alienist testimony and advocated that



only state-hired psychiatrists pass on a defendant's sanity. In an address at the convention of the State Medical Society of Connecticut, he made these points:

1. Psychiatrists often present a ridiculous picture in court by giving contradictory testimony. As a result, crime is elevated, law debased, and medicine prostituted.

2. The accused cannot hire the judge or the jury. Therefore, he should not be permitted to hire an alienist to pass judgment on him.

Dr. Kennedy used those points in support of his contention that the decision as to a defendant's sanity should be left entirely to a single psychiatrist or to a panel of such experts retained by the court, not by the defendant. He cited Supreme Court Justice Benjamin M. Cardozo's declaration that in cases involving sanity, the judge should consider the alienist as his invaluable ally—in some cases, relinquishing final judgment to him.

MEDICINE IN CONGRESS

Three measures affecting medicine are pending in Congress: Senator Hugo Black's resolution (S. Res. 143) for a congressional survey and study of national public health and the Bone-Magnuson and Maverick cancer bills.

Senator Black's plea for a nationwide health survey is substantially the same as the one he made several years ago and withdrew because of A.M.A. opposition. He decided to reintroduce the resolution immediately after the A.M.A., at its recent convention, expressed its willingness to cooperate in such a study.

The two cancer measures may be coordinated into one. The Bone-Magnuson proposal calls for an annual appropriation of $1,000,000 for the control and prevention of cancer. The Maverick bill has the same purpose, but it calls for a $2,400,000 initial appropriation plus an annual $1,000,000

contribution from the government. Furthermore, the Maverick bill would set up a national cancer center in Washington, while the Bone-Magnuson measure makes no provision for research buildings.

Of the two, the Bone-Magnuson bill is more flexible. It would let the profession compile its technical provisions. Both measures vest administration of anti-cancer funds in the U. S. Public Health Service.

Joint committee hearings on the cancer bills were held last month. Among those who testified were representatives of the American Society for the Control of Cancer; the Mayo Clinic; the A.M.A.; the Royal College of Surgeons, England; the Bell Telephone Laboratories; General Electric's research division; the National Academy of Science; and the Cancer Research Council.

The Bone-Magnuson measure carries the endorsement of 94 out of 96 senators. Its support in the house is proportionate. That, plus the fact that the Bone-Magnuson and Maverick bills may be merged, indicates that anti-cancer legislation will be passed in both houses as soon as it reaches the floor. However, since congressional business is so rushed at present, the measures may not come up for consideration until the next session.

"FOURTH" CLAIMS SIX

Public health officials in many states joined with Dr. Thomas Parran, Jr., surgeon general of the U. S. Public Health Service, in reiterating the perennial plea for "a safe and sane Fourth." Via radio and news releases, parents were urged to withhold fireworks from offspring more careless than patriotic. Mothers and fathers who complied were rewarded by reading post-Independence-Day headlines to the effect that 1937's "Fourth" was

SMALLPOX VACCINE, Mulford

THE Mulford Biological Laboratories have pioneered in the development of smallpox vaccine. Since the introduction of Smallpox Vaccine, Mulford in 1898, continued research and the accumulating experience of thirty-nine years' production have developed a product in keeping with current scientific knowledge.

There has been progress in product and package—from the technic of scab vaccination, through the old-fashioned dry ivory points, dry glass points, glycerinized glass points, to the Mulford Improved Capillary Tube-Point. The latter is a sterile, sealed vaccine container and inoculating instrument all in one. It is ready for immediate use with any of the approved technics—multiple pressure, puncture or scratch.

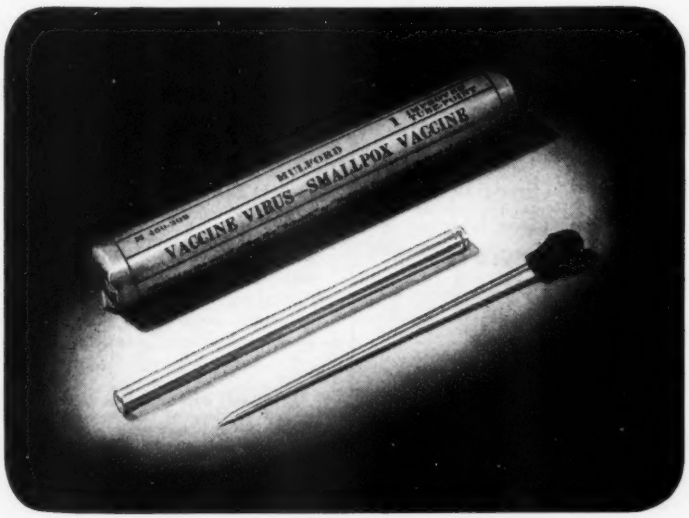
* * *

Smallpox Vaccine, Mulford is subjected to exhaustive tests which assure its potency and purity before release. For this reason it produces a high percentage of successful vaccinations in non-immune individuals. Smallpox Vaccine, Mulford is supplied in these convenient packages: Capillary Tubes, 5's and 10's, and Improved Capillary Tube-Points, singles, 5's and 10's.

"For the Conservation of Life"

MULFORD BIOLOGICAL LABORATORIES

PHILADELPHIA **SHARP & DOHME** *BALTIMORE*



the safest and sanest on record as far as fireworks were concerned—only six deaths being attributed to them.

MORGUE HOLIDAY

Grateful, but surprised was Dr. Thomas A. Gonzales a few weeks ago when a whole day slipped by without a single autopsy being referred to his office at the Manhattan morgue.

Dr. Gonzales, who has served in New York City's chief medical examiner's office since 1918 cannot remember any other day during which no new cases came to the morgue. The daily average is ten.

DISABILITY RACKET DRIVE

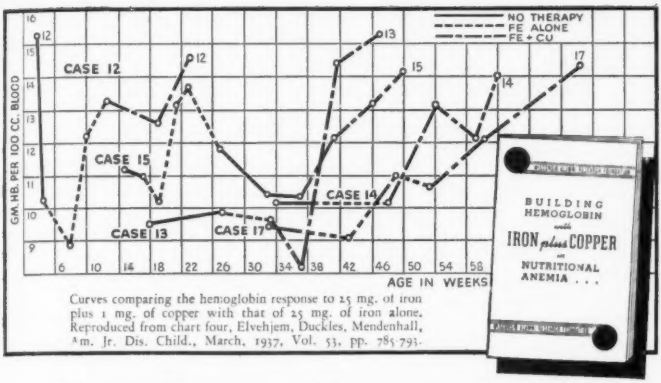
Legal authorities attempting to wipe out the disability insurance racket have admitted their inability to cope with the medical skulduggery on which its success is based. Consequently, a medical aide, Dr. Oswald Hedley, of the U. S. Public Health Service, has been assigned to the U. S. Attorney's office in New York.

The fake disability game is played like this: Heavily insured claimants are coached and doctored (with purges, digitalis, and exhausting exercise) into shining examples of disabling diseases—usually cardiac. Then they are sent to reputable specialists whom they dupe into certifying their fraudulent claims*.

RESOLVED ON FAIR FEES

Arbitrarily, without consulting the local county medical society, the Lawrence County (Ohio) Welfare Bureau early this year set a fee of $15 for obstetrical services to relief clients. Convinced that such action was as unfair as it was high-handed, Lawrence

*Mercilessly duped was Dr. John Henry Wyckoff, president of the American Heart Association and dean of the New York University Medical School. Immediately after being informed of his unwitting collusion, he was found in a state of collapse in the university's anatomical laboratory. He died shortly afterwards.



Curves comparing the hemoglobin response to 25 mg. of iron plus 1 mg. of copper with that of 25 mg. of iron alone. Reproduced from chart four, Elvehjem, Duckles, Mendenhall, Am. Jr. Dis. Child., March, 1937, Vol. 53, pp. 785-793.

Up Goes Hemoglobin

When Copper-Iron Compounds Are Used To Correct NUTRITIONAL ANEMIA!

Hemoglobin regeneration in nutritional and related anemias is best effected when the iron dosage is supplemented with sufficient copper to activate it

This vital discovery, especially important in the treatment of anemic infants and children, was made by Prof. E. B. Hart of the University of Wisconsin and is supported in published reports by eminent authorities. Abstracts of these studies, together with much other interesting material on copper-iron therapy, are now available in a new booklet "Building Hemoglobin with Iron Plus Copper in Nutritional Anemia".

Among the topics discussed are: Availability of Food Iron and Food Copper; How Much Iron A Child Needs . . . How Much Copper; Research Reports Showing the Greater Efficiency of Iron and Copper; How Commercial Iron Salts Vary in Copper Content. This booklet is sent gratis upon request. The coupon below is for your convenience.

Copper is the natural activating agent for iron in hemoglobin building. A small amount of iron plus copper is effective, and with greater certainty in its action than iron alone. Consequently standardized preparations of iron and copper salts are the only ones that can constantly be depended upon for optimum activity.

Foundation-licensed Copper-Iron Compounds combine copper with iron in the proper proportions *at all times*. They are produced with a most careful background of research and control and are distributed by many leading pharmaceutical houses throughout the country. These products, specifics for nutritional anemia, may be identified by the statement: "Manufactured under license from the Wisconsin Alumni Research Foundation, Hart Patent No. 1,877,237."

WISCONSIN ALUMNI RESEARCH FOUNDATION, MADISON, WISCONSIN*

★A corporation not for private profit . . . founded in 1925 . . . to accept and administer, voluntarily assigned patents and patentable scientific discoveries developed at the University of Wisconsin. By continuous assays the professional confidence in these accurately standardized copper-iron compounds is maintained. All net avails are dedicated to scientific research.

Wisconsin Alumni Research Foundation, Madison, Wisconsin ME 837

Please send the booklet "Building Hemoglobin with Iron Plus Copper in Nutritional Anemia."

Name .....

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City ..... *State* .....

County physicians decided to protest. As a result, no member of the Lawrence County Medical Society, if he abides by a resolution adopted at a recent meeting, will handle relief obstetrical cases on any but the following bases: (1) a minimum fee of $25 for cases within five miles of the attending physician's office, mileage to be charged for calls beyond that limit; (2) the minimum fee to cover two pre-natal and two post-natal calls; (3) an additional fee of $10 to be paid in abnormal cases, plus another $10 to be paid to an assistant called in on a case.

"WELL DONE!"—SANGER

The work of the National Committee on Federal Legislation for Birth Control "is done and well done," announced Margaret Sanger, executive head of the committee, last month. Thus, she dissolved the unit which for years has campaigned so militantly for contraception. She indicated that the A.M.A.'s official recognition of birth control as a legitimate phase of medicine leaves no necessity for the committee.

BLEAT FOR "FREEDOM"

A would-be thorn in the side of the A.M.A. is being nurtured in Oklahoma City by naturopathy's nabob, Benedict Lust, of New York City. Called the Medical Freedom Association, it is a conglomeration of naturopaths, chiropodists, spiritualists, and other drugless healers. Its avowed purpose is to "combat the racketeering methods" of the A.M.A. and to effect the discard of Oklahoma's new basic science law.

Lust has placed William Scopel, chiropodist, at the head of the organization; Pastor A. E. Smith, of the National Spiritualist Church, is vice-president; Harry F. Bergman, president of the Oklahoma Naturopathy Association, is secretary-treasurer. A

membership of 30,000 is hoped for. All expenses—including the cost of contemplated publicity through pamphlets, soap-boxers, etc.—will be prorated among members.

Chiropodist Scopel has stated, "I expect to spend some time in jail. But my reason for joining this movement is based on my sincere opinion that it is to the public interest to curb activities of any group that goes too far."

Dr. P. M. McNeill, president of the Oklahoma County Medical Society, echoing the opinion of his fellow members, finds the new organization "no cause for alarm."

TROUBLE WITH RELIEF

The city fathers of Berlin, N. H., contracted recently to pay an annual fee of $5,000 to three members of the staff at a local hospital. The doctors, in return, agreed to provide medical service to relief patients. Bitter controversy followed. Other members of the hospital staff protested. They cited their right to share in city "business." Their counterproposal which would have permitted them to do so was rejected. Indignation led thirteen members of the staff to resign. Following that, authorities at the institution dissolved the entire staff. New medical personnel is being recruited from members of local and nearby county medical societies.

BEWARE THE TELEPHONE

A four-point warning against telephone solicitors who seek donations for fake charities has just been issued by New York City's department of public welfare:

Don't put too much faith in telephone solicitations from "judges," "commissioners," "senators," or "congressmen." Public officials seldom seek to aid fund-raising campaigns in this manner.

Don't let religious titles influence you unless you know the solicitors are

the institutions they represent.

Don't permit telephone solicitors to "rush" you.

Don't donate without investigating first.

BIRTHS EBB, DEATHS RISE

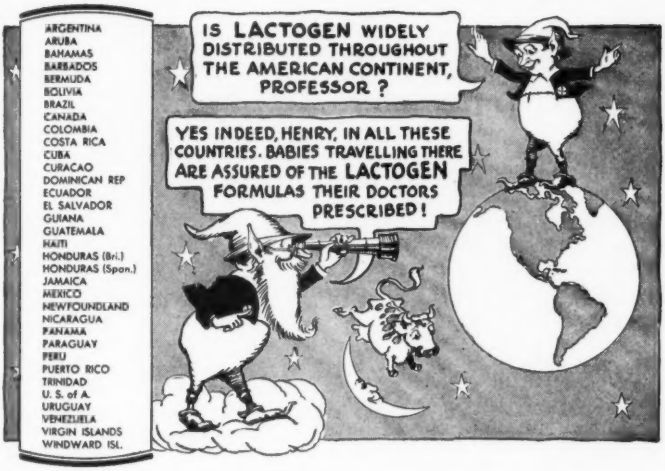
The United States' 1936 birth rate of 16.6 live babies born per thousand of estimated population was only .1 baby higher than 1933's all-time low, according to a recent report of the U. S. Census Bureau. This was the second consecutive year that the birth rate had dropped. The report shows a decline in 31 states, no change in three, and slight increases in fourteen states and in the District of Columbia. New Mexico rates highest with 29 live births per thousand; New Jersey, lowest with 12.4. The country's total 1936 birth registration was 2,136,039.

The Census Bureau has also revealed that the nation's death rate for 1936 was the highest since 1929—11.5 per 1,000. Cited as principal causes of the seven-year high mark are the heat wave of a year ago last month and the increase in deaths from respiratory ailments which took place early in 1936. North Dakota had the lowest death rate—8 per 1,000; Arizona, the highest—15.5 per 1,000. The national mortality total was 1,474,177.

TABS ON IMMUNIZED BLOOD

Every physician treating streptococcic infections would keep a special record of such patients and their blood type if Dr. John A. Kolmer, of Temple University, Philadelphia, had his way. Speaking before the recent convention of the American Laryngological, Rhinological, and Otological Society in Atlantic City, he pointed out that by maintaining such a list of potential donors of immunized blood, transfusions to save the lives of others might more readily be secured.

[TURN THE PAGE]



When your choice is powdered milk prescribe a milk modified by the addition of milk sugar and homogenized milk fat

Realizing the need for a properly modified cow's milk in powdered form, that is, a product containing the milk constituents in the proper proportions for Infant Feeding but containing nothing but milk constituents, Nestlé's Milk Products, Inc., devised their product known as LACTOGEN, and its reception and increasing use by the medical profession is sufficient proof that it fills an important need and that its quality and reliability are all that can be desired.

A spray dried Cow's Milk modified by the addition of milk fat and milk sugar. The only available product made entirely from *milk* which, when liquefied, results in a formula approximating Woman's Milk in percentages of milk fat, milk protein, milk sugar and minerals (ash).

For Literature and Samples of LACTOGEN, please send professional blank to

NESTLÉ'S MILK PRODUCTS, Inc.

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Dr. Kolmer, poliomyelitis vaccine originator, cited a number of striking recoveries obtained by transfusing blood from persons convalescing or recently recovered from streptococcic infections. What is needed, he said, is "some chemical agent which will disinfect the fixed tissues and the blood when given in non-toxic amounts. The nearest approach to this ideal is a blood transfusion from a convalescent, compatible donor."

During his discussion of the treatment of septicemia with serum, Dr. Kolmer declared that the most common mistake was in delaying and then being timid about the size of the dose. "We have superior anti-streptococcus serums in this country," he said, "I plead for their administration early and in adequate doses."

TO LOWER THE HIGHWAY TOLL

Despite safety programs instituted all over the country, highway accidents caused 20% more deaths in the first five months of this year than during the same period of 1936, says a recent report of the American Automobile Association.

Meantime, added support is being lent to the proposal that all drivers be required to undergo periodic medical examinations. That precaution is one of several urged by the Young Men's Board of Trade of New York following an intensive survey of traffic and highway conditions. The board recommends compulsory physical examinations at the drivers' expense every five years. Such check-ups would be given at authorized state hospitals. The board has unearthed numerous cases to prove the need for a rigorous weeding-out process. The following are typical: a man who returned to the wheel within a few weeks after having had his arm amputated; an admitted lover of speed who hastened to the driver's seat immediately upon his release from a mental institution. Such people, the board laments, renew

their driving licenses annually without question as to their physical or mental capacity.

The citizens of Augusta, Georgia have met the traffic-accident challenge with something more than recommendations. Under the direction of local physicians and the Red Cross, scores of Augustans have signed up to donate blood to accident victims in need of a transfusion. Donors will be speeded to operating rooms in radio patrol cars. If the plan works successfully in Augusta, the Red Cross plans to promote it nationally.

MASS SWOONINGS

Professor Jules Le Clerc, director of the Lille (France) Legal, Social, and Medical Institute, was caught on the horns of a dilemma recently when asked to diagnose two wholesale faintings of young girl employees in a local sugar refinery. "Humidity," deduced the professor after investigating the first prostration of nearly a hundred girls on a sweltering day. Five days later, in relatively cool weather, a group of seventy girls toppled over. That compelled Professor Le Clerc to revise his diagnosis. Since only the weaker constitutioned girls fainted, he and his colleagues decided the swoonings were due to "auto-suggestion," and classified them as resulting from "excessive nervousness on a large scale."

ONE BIRTH, THREE DEATHS

Birth was completely outplayed by death in Shoals, Indiana recently when a young woman, her unborn child, and one of two attending physicians died during a forceps delivery.

Dr. E. E. Long, the patient's physician, had called Dr. Charles F. Hope to assist him with the delivery at the patient's home. During the delivery, Dr. Hope suddenly crumpled.

Dr. Long, abandoning his patient

for a moment, rushed to his colleague's side only to find that he had died instantly. Quickly returning to his patient, Dr. Long discovered that she and her as yet undelivered baby were both dead also.

BOOST FOR CANCER RESEARCH

Philanthropy has recognized the much-emphasized need for funds to support cancer research. June commencement exercises at Yale University were featured by the announcement of a $10,000,000 gift to the New Haven institution to establish the Jane Coffin Childs Memorial Fund for Scientific Research.

The grant was made by Starling W. Childs, New York investment banker, as a memorial to his wife whom cancer claimed last year. It is to be devoted primarily to inquiry into the causes of cancer. This single generous gesture, it is estimated, has increased the annual sum available for cancer research by about 50%.

In acknowledging Mr. Childs' gift, Yale's President Angell, described it as "the greatest opportunity ever given to one of our universities." The foundation will cooperate closely with the Yale Medical School and will be administered by a board of managers guided by a scientific advisory board including Dr. Stanhope Bayne-Jones, dean of the Yale Medical School; Drs. Rudolph J. Anderson, Ross G. Harrison, and Milton C. Winternitz, all of Yale; and Dr. Peyton Rou, of the Rockefeller Institute for Medical Research.

Before the new $10,000,000 anti-cancer fund was created, the largest similar endowment was the $2,000,000 given the International Cancer Research Foundation of Philadelphia.

JEWS NO THREAT

"The fear that Jews will dominate the key professions is groundless," maintains Rabbi Louis I. Newman, well-known theologian. In a recent sermon

before his New York City congregation, he pointed out that simply because there is a plethora of Jewish physicians in certain metropolitan areas there is no foundation for the opinion that Jews are ascendant in the profession throughout the United States. He decried well-meaning advice from Gentile friends that Jews avoid a medical career and seek non-professional employment instead.

Rabbi Newman reiterated a contention that he made several years ago when Dr. James L. McConaughy, president of Wesleyan University, issued a much-publicized warning of special difficulties ahead for Jews in medicine. Said he, "If individual Jews have talent for medicine, they should be given opportunity to fulfill themselves to the utmost."

JUST PUBLISHED

ARTICLES

How healthy are we? by Mary Ross. A report on the national health inventory undertaken by the federal government. (*Survey Graphic*, July, 1937)

The first woman doctor, by Ida Clyde Clark. (*Coronet*, July, 1937)

Can doctors end the fee racket, by Frederick L. Collins. A discussion of fee splitting. (*Liberty*, July 10, 1937)

Patient's progress, by Don Daugherty. The last in a series on "human suffering." (*Coronet*, July, 1937)

Diseases of darkness, by Thomas J. Kirwin. The war against syphilis and gonorrhea in the United States. (*Forum*, July, 1937)

Laboratory tests for marriage, by A. Frederick Mignone. Facts about

the Connecticut law requiring premarital tests for venereal disease. (*Survey Graphic*, July, 1937)

MEDICINE'S RED HORIZON, by Bertram B. Fowler. Organized medicine's battle against the Elk City (Oklahoma) Hospital. (*Forum*, July, 1937)

WE CAN END THIS SORROW, by Paul de Kruif and Dr. Thomas Parran. Ways to eradicate syphilis. (Ladies' Home Journal, August, 1937)

BOOKS

THE TRAFFIC IN HEALTH, by Charles Solomon, M.D. About patent medicines and cosmetics. (Navarre, $2.75)

HEALTH EDUCATION OF THE PUBLIC, by W. W. Bauer, M.D. and Thomas G. Hull. (Saunders, $2.50)

REPORT OF THE HOSPITAL SURVEY FOR NEW YORK, Volume 2. (United Hospital Fund, $2.50)

SEVEN KINDS OF INFLATION AND WHAT TO DO ABOUT THEM, by Richard D. Skinner. (Whittlesey House, $2.50)

SOCIAL SECURITY, 1937. Proceedings of the tenth annual conference of the American Association for Social Security, including a section on health insurance. (American Association For Social Security, $2)

SISTER OF THE ROAD. The autobiography of a woman hobo, as told to Ben L. Reitman, M.D. (Macaulay, $2.50)

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LITERATURE & SAMPLES

RUBBER NIPPLES: Complete information on Hygeia nursing bottles and nipples is contained in a leaflet issued recently by the Hygeia Nursing Bottle Company (ME 8-37), 197 Van Rensellaer St., Buffalo, N. Y. The nipples, it says, are breast-shaped, easily inverted, easy to clean, and are equipped with patented tabs which keep them germ-free. A copy of the leaflet will be forwarded to you promptly upon request.

VITAMIN E: So that you may test the therapeutic value of Embry-E in your own practice, the Cole Chemical Company (ME 8-37), invites you to send for a free sample. According to literature describing this preparation, it is a cold-pressed wheat germ oil rich in vitamin E. Embry-E is prescribed in the treatment of habitual abortion, sterility, deficient lactation, and acne vulgaris.

PAIN: Have you prescribed Hyosed in cases where it is necessary to dull pain and produce sleep? If not, Walker Corp & Co., Inc. (ME 8-37), Syracuse, N. Y., will gladly send you a supply for clinical trial. The product is a combination of phenyl-ethyl-malonyl-urea, dimethylamino-antipyrine, and hyoscyamus extract.

STERILIZER TABLETS: Do you have trouble keeping your instruments bright and shiny? If so, try a free sample of Castle Sterilizer Tablets. They tend to absorb the oxygen from the water and prevent your instruments from becoming tarnished. At the same time they soften the lime coating in the sterilizer, making cleaning easier. Write the Wilmot Castle Company (ME 8-37), Rochester, N. Y.

ROTARY PUMP: A handsomely illustrated catalog just issued by the Gomco Surgical Mfg. Corp. (ME 8-37), 87-91 Ellicott St., Buffalo, N. Y., highlights the unique features of the concern's new electric rotary pumps. These units are equipped with safety floats, provide position filtration, and are said to afford both high pressure and compactness.

ANESTHETIC AND ANTISEPTIC: The makers of Orax Throat Tablets offer you a free sample of their product together with literature describing it. This new preparation is said to be an effective local anesthetic and antiseptic of high potency and low toxity, acting as a prompt and definite check against pain. Send your request to the Medico Chemical Corporation of America (ME 8-37), 15 East 40th St., New York, N. Y.

HYPERACIDITY: An eight-page booklet which reviews the advantages of Magsorbent in treating gastric ulcer and hyperacidity is available on request. The product is a synthetic hydrated magnesium trisilicate with a dual action. First, says the booklet, it produces a sustained antacid effect which is continuous and prolonged; second, it acts as a powerful absorbent and detoxifier. Besides the booklet,

you can get a complimentary package of Magsorbent for clinical trial. Address E. Fougera & Company (ME 8-37), 75 Varick St., New York, N. Y.

MEDICINAL WHISKEY: The National Distillers Products Corporation (ME 8-37), 120 Broadway, New York, N. Y., has compiled for the medical profession a complete index of recent medical literature on the subject of "Whiskey As Medicine." You'll no doubt want a copy for the helpful facts it contains.

COLLECTION SYSTEM: A free Physicians' Collection System for you to try on your delinquent accounts will be sent to you on request by Arrow Service (ME 8-37), Arrow Bldg., Schenectady, N. Y. It embraces the use of a notice mailed out in the same manner as a monthly statement. Those who have used it, says Arrow Service, find that it produces results without harming in any way the relationship between physician and patient.

NUTRITION FACTS: Seventy-five handy file cards of food facts are yours upon request. They measure 5" x 7" and contain abstracts from published reports of scientific research on human food requirements and the nutritive contents of specific canned foods. Drop a card to the American Can Company (ME 8-37), 230 Park Ave., New York, N. Y.

HYGIENIC POWDER: Mu-Col is described in a new leaflet as a non-poisonous, saline-alkaline prophylactic and bacteriostatic for vaginal cleansing and for treating all mucous areas. Its formula combines neutral and alkaline salts with menthol, thymol, and other bland essential oils that give it a delightful aroma. Besides the leaflet, a generous sample is available. Drop a card to the Mu-Col Company, Inc. (ME 8-37), Buffalo, N. Y.

INFLAMMATORY PROCESSES AND THEIR TREATMENT: Here's an interesting brochure that details the many uses of Antiphlogistine. The preparation's heat-retaining, hygroscopic, and therapeutic qualities are said to make it an ideal prescription for vacation-time injuries, such as sprains, strains, bruises, insect stings, and other inflammatory conditions. A generous sample will be sent to you along with the literature. Address The Denver Chemical Mfg. Company (ME 8-37), 163 Varick St., New York, N. Y.

STEEL FURNITURE: Before you decide definitely just how you'll refurnish your office or reception room, write for this attractive catalog. It displays in full color the numerous models of Howell Chromsteel Furniture. Write the Howell Company (ME 8-37), St. Charles, Ill.

DIABETES MELLITUS: Here's an offer of a trial supply of Pancrepatine, together with literature telling all about it. The product combines hormones of the pancreas and liver and has been used with marked success in the oral treatment of diabetes mellitus. Send your request to the Anglo-French Drug Company, Inc. (ME 8-37), 1270 Broadway, New York, N. Y.

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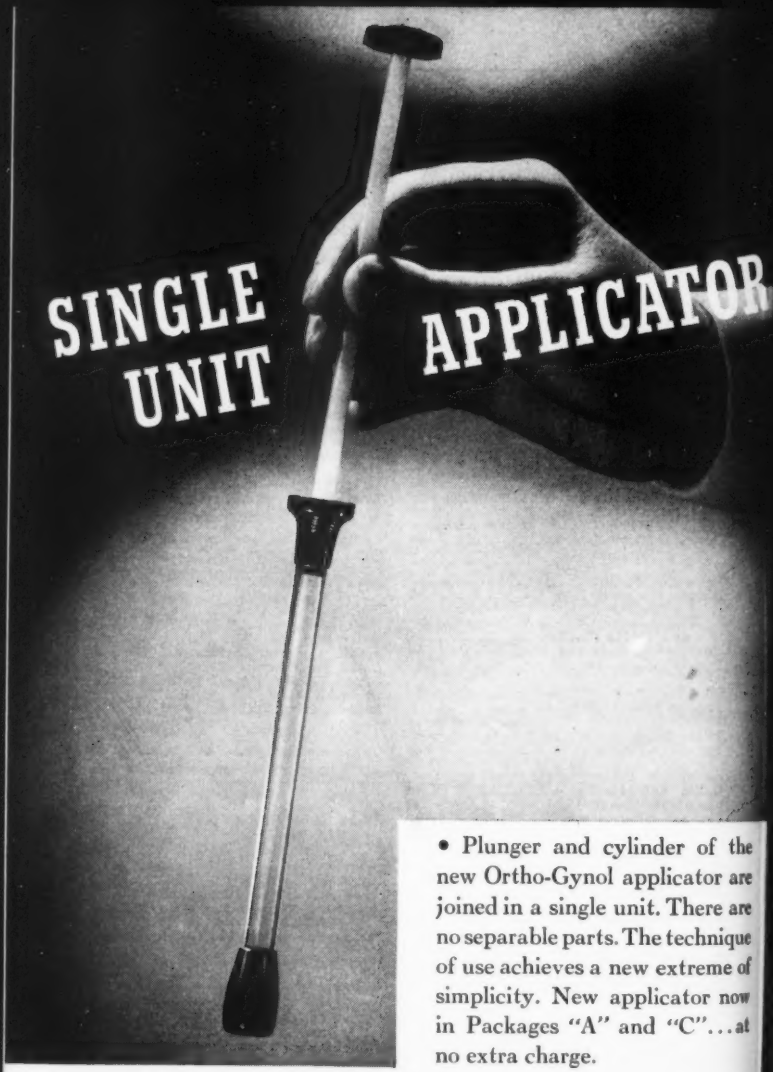

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